STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414090	A. BUILDING _____ B. WING _____	8/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COREWELL HEALTH REHAB & NURSING CENTER - KENTRIDGE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Corewell Health Rehab and Nursing Center-Kentridge was surveyed for a Recertification survey from 8/13/24 - 8/15/24. Intakes: MI00143848, MI00143347 Census=135	F0000		
F0554 SS= D	Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were assessed for self-administration of medications for 3 (Resident #84, 44 and 74) of 5 residents reviewed for self administration of medication, resulting in unsupervised administration of medications and the potential for mismanagement of medication and potential for adverse side effects. Findings include: Resident #84 Review of an "Admission Record" revealed Resident #84 was originally admitted to the facility on 1/26/21 with pertinent diagnoses which included vascular dementia without behavioral disturbance. Review of Resident #84's "Orders" revealed " Hydrocodone-acetaminophen (norco) (opioid	F0554	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Corewell Health Rehabilitation & Nursing Center Kentridge wishes to have this plan of correction stand as its written statement of compliance. F554 Resident Self-Admin Meds-Clinically Appropriate Element #1 Residents #84, #44, and #74 have been assessed and confirmed that none are appropriate for self-administration of medications. Element #2 All residents residing in the facility as of August 15, 2024 have the potential to be affected. Element #3 The Medication Management Policy has been reviewed and deemed appropriate by the facility Nursing Home Administrator, Director of Nursing, and Nurse Educator.	9/19/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/03/2024

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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	pain medication) 5-325 mg per tablet. Dose: 1 tablet. Freq (frequency): 3 times daily. Route PO (by mouth)..." During an observation and interview on 8/13/24 at 12:40 PM, Resident #84 approached Licensed Practical Nurse (LPN) "H" and requested her pain medication. LPN "H" took Resident #84's medication from the medication cart and placed one pill in a medication cup and then handed the cup to Resident #84. Resident #84 placed the medication cup on her walker and began walking towards her room. LPN "H" reported that she did not need to observe Resident #84 take her medication and that she always stopped for her pain pill on her way to her room after lunch. LPN "H" did not know if Resident #84 had been assessed to safely self administer medications without supervision. LPN "H" reported that the pill she had given Resident #84 was norco. At 8/13/24 at 12:41 PM, LPN "H" walked down to Resident #84's room door and asked her from the doorway if she "had taken her pain pill". LPN "H" did not enter Resident #84's room. During an interview on 8/14/24 at 9:50 AM, Registered Nurse (RN) "U" reported that Resident #84 was not able to take medication without supervision. RN "U" reported that Resident #84's medications were supposed to be crushed and administered in applesauce. RN "U" reported that Resident #84 could be forgetful and therefore it would not be safe for Resident #84 to self administer her medications without supervision. During an interview on 8/15/24 at 10:38 AM, Nurse Supervisor (NS) "C" reported that it was her expectation that nurses observe residents when administering medications, especially narcotic medication. NS "C" reviewed Resident #84's electronic health record (EHR) and		The Nursing Home Administrator, Director of Nursing, and Nurse Educator have reviewed and confirmed the following education/orientation for direct care licensed nurses and deemed it appropriate: 1. New Employee Orientation Training: CHW RNC Medication Administration (online learning module) 2. New Employee Orientation Training: Medication Administration: Competency Evaluation (completed during floor orientation) 3. CHCC Orientation Validation Tool (OVT) Rehabilitation & Nursing Centers (RNC) Licensed Nurse 4. Annual RNC Nursing Skills Fair 2024 (September-October 2024): Medication Administration station to include correctly prepare, administer, dispose of, and document medications (oral pills, crushed meds, narcotic meds, insulin, inhalers, and eye drops) All direct care licensed nurses will be re-educated in medication management and administration to ensure appropriate supervision with administration of medications and correct management of medication. Element #4 A quality-assurance program was implemented under the supervision of the Director of Nursing to monitor compliance in medication management and administration to ensure appropriate supervision with administration of medications and correct management of medication. The Director of Nursing or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking of compliance with resident self-administration of medication assessment status and appropriate supervision provision	

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	confirmed that Resident #84 had not been assessed for self administration of medications and she did not have an order to self administer medications without supervision. NS "C" reported that Resident #84 was not be eligible to self administer medications as she was at high risk for aspiration. Review of the facility's "Medication Management" Policy, dated 4/21/2023, revealed, " ...Resident Self-Administered Medications (SAM). 4.10.1. Evaluate resident ' s cognition, vision, and fine motor abilities.4.10.2. Prescriber order is required for a resident or designee (e.g., parent) to self-administer medications. 4.10.3. Prior to initiating the licensed personnel must teach resident/ designee how to self administer and resident/ designee must demonstrate competency. 4.10.4. All medications must be stored in designated medications storage areas. 4.10.5. Medications must be in locked storage when kept in the room. 4.10.6. Medications used for self-administration shall be medications that are used to manage conditions of which the resident/ designee understands the medication, dose, frequency, associated adverse drug reactions. 4.10.7. Nurse must monitor and validate SAM administration and document as required in eMAR..." Resident #44 Review of an "Admission Record" revealed Resident #44, was originally admitted to the facility on 3/23/23 with pertinent diagnoses which included: chronic back pain, functional tremor, chronic heart failure (condition causing poor blood circulation), type 2 diabetes mellitus (condition causing elevated blood sugars), dysphagia (difficulty swallowing), and choking. Review of a "Minimum Data Set" (MDS)		with administration of medications. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by September 19, 2024. The Administrator is responsible for sustained compliance.	

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	assessment for Resident #44, with a reference date of 6/19/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #44 was cognitively intact. Section "E" of the MDS revealed Resident #44 did not experience hallucinations or delusions (false beliefs about reality) and did not reject care. Review of physician's orders for Resident #44 revealed she was prescribed more than 30 medications including an anticoagulant (blood thinner), a narcotic (prescription strength pain medication), an anti-spasmatic (muscle relaxer), and a diuretic (drug that causes the body to remove extra fluid). During an observation on 8/13/24 at 10:04, Resident #44 sat at the edge of her bed, leaned forward and picked medications up off the floor. The resident then placed the medications in her mouth. No staff were present in the room. In an interview on 8/13/24, at 10:06am, Resident #44 reported the nurse left her medications on the table in a small clear cup and Resident #44 spilled the medications on the floor when she tried to take them. Resident #44 stated "I think I got most of the medications", referring to her attempt at self-administering her medications. Resident #44 reported she had a difficult time seeing the medications and was not sure what she took. Resident #74 Review of an "Admission Record" revealed Resident #74, was originally admitted to the facility on 9/4/21 with pertinent diagnoses which included: hypertension (high blood pressure), type 2 diabetes mellitus (condition resulting in elevated blood sugar levels), intracranial hemorrhage (rupture of arteries or blood vessels in the brain), and end stage renal disease.			

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	Review of a "Minimum Data Set" (MDS) assessment for Resident #74, with a reference date of 5/29/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #74 was cognitively intact. During an observation on 8/13/24 at 2:47pm, 2 clear medication cups, 1 with approximately 5 white pills, 1 with 2 white, large disk-shaped medications, sat on Resident #74's bedside table. No staff were present in the room. The door to the room was open.			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately assess, monitor, treat, and implement interventions for a residents with pressure ulcers for 1 (Resident #27) of 3 residents reviewed for pressure ulcers resulting in the worsening condition of a pressure ulcer. Findings include:	F0686	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Corewell Health Rehabilitation & Nursing Center Kentridge wishes to have this plan of correction stand as its written statement of compliance. F 686 Treatment/Services to Prevent/Heal Pressure Ulcers Element #1 Resident #27 has been re-assessed by the Wound Care Nurse, continues to be monitored weekly during wound rounds by the Wound Nurse and Nurse Supervisor or designee, treated daily per physician orders by direct care nurses, and his Care Plan/RCS includes pressure ulcer interventions. Element #2 All residents with pressure ulcers residing in the facility as of August 15, 2024 have the potential to be affected.	9/19/2024

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	Resident #27 Review of an "Admission Record" revealed Resident #27 was originally admitted to the facility on 2/23/21 with pertinent diagnoses which included pressure injury of left buttock, stage 3. Review of a "Minimum Data Set" (MDS) assessment for Resident #27, with a reference date of 6/4/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #27 was cognitively intact. Review of Resident #27's "Care Plan" revealed, " (Resident #27) has a stage 3 pressure injury... Goal: (Resident #27) will demonstrate improvement in skin integrity AEB (as exhibited by) no signs and symptoms of infection. Interventions:... monitor for s/sx (signs and symptoms) of infection: warmth, redness, tenderness, swelling, decline in healing, fever, increased drainage.. treatments- see orders and/or work lists tasks... start date: 11/21/22" Review of Resident #27's "Orders" on 8/15/24 revealed, " ...Wound Care: Wound Dressing-daily.Comments: Perianal wound: Irrigate wound with NS (normal saline), cut 1/8 inch wide, 1/2 inch long plain packing strip. Line the packing strip with Woun' Dres gel. Fill wound with packing strip. Cover with foam dressing.." Review of Resident #27's "Wound care treatment orders" for July 2024 revealed a treatment was not documented as completed on 7/4/24. Review of Resident #27's "Wound care treatment orders" for August 2024 revealed a treatment was not documented as completed on 8/8/24.		Element #3 The Pressure Injury Policy has been reviewed and deemed appropriate by the facility Nursing Home Administrator, Director of Nursing, and Wound Care Nurse. The Wound Care Nurse has completed Wound Care Certification. Certification number: 240529178. Issued 7/29/2024 and expires 7/29/2029. The Nursing Home Administrator, Director of Nursing, and Nurse Educator have reviewed and confirmed the following education/orientation for direct care licensed nurses and deemed it appropriate: 1. New Employee Orientation Training: SHCC RNC Skin Care and Pressure Injury Prevention (online learning module) 2. CHCC Orientation Validation Tool (OVT) Rehabilitation & Nursing Centers (RNC) Licensed Nurse Wound Care Nurse leads weekly wound rounds on all units, attends daily nursing huddles to provide ongoing education and answer questions, and sends routine wound guidance/education email notifications. All direct care licensed nurses will be re-educated on pressure ulcer assessment, monitoring, treatment, and implementation of interventions. Element #4 A quality-assurance program was implemented under the supervision of the Director of Nursing to monitor compliance in pressure ulcer assessment, monitoring, treatment, and implementation of interventions. The Director of Nursing or designated quality-assurance representative	

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	Review of Resident #27's "Wound Assessment" dated 7/26/24 revealed, " wound length: 0.3 cm, wound width 0.2 cm, wound depth 0.2 cm..." Review of Resident #27's Wound Assessment" dated 8/14/24 revealed, " wound length: 1 cm, wound width 0.3 cm, wound depth 0.8 cm.." During an interview on 8/14/24 at 12:31 PM, Resident #27 reported that staff were frequently skipping his daily wound care treatment for his stage 3 pressure wound. Resident #27 reported that the facility had recently missed completing the wound care treatment for 4 days in a row. Resident #27 reported that he had voiced his concerns about treatments being skipped to Wound Care Nurse "PP". During an interview on 8/15/24 at 9:22 AM,Wound Care Nurse, "PP" reported that Resident #27's wound dressing was ordered to be changed daily. Wound Care Nurse "PP" reported that Resident #27 had informed him that facility staff were missing his wound care treatments and had recently missed treatments for four days in a row. Wound Care Nurse "PP" reported that Resident #27's pressure ulcer was noted to have increased in size at the last assessment. Wound Care Nurse "PP" reported that he had recently changed Resident #27's wound treatment to be completed during the day shift because the night shift staff were inconsistent with completing treatments. Wound Care Nurse "PP" reported that nurses were suppose to document the wound care treatment as completed under the "work list" section of the electronic health record (EHR) and they were also suppose to document an assessment under the "flowsheet" section of the EHR. Wound Care Nurse "PP" reviewed Resident #27's EHR with this surveyor and reported that nurses had been signing off the wound care treatment as completed, but there was not		will perform the following systematic changes: randomly checking, or weekly checking of compliance with pressure ulcer assessments, monitoring, treatment, and interventions. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by September 19, 2024. The Administrator is responsible for sustained compliance.	

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	documentation of a wound assessment from 7/26/24 to 8/8/24. Wound Care Nurse "PP" reported that he had reported that staff were missing wound care treatments for Resident #27 to Nurse Supervisor (NS) "C". During an interview on 8/15/24 at 10:16 AM, Registered Nurse "AA" reported that she had recently missed completing the wound care treatment for Resident #27. RN "AA" reported that it was easy to miss treatments in the evening if the unit was busy. RN "AA" reported that she did not know how to document the wound care treatment as missed in the work list, so she had to sign off on it as completed. RN "AA" reported that she had asked management how to correctly document a missed treatment, but she had never gotten an answer on what to do, so she continued to document the treatment as completed even when it was missed. During an interview on 8/15/24 at 12:51 PM, Licensed Practical Nurse (LPN) " P" reported that she had missed Resident #27's wound care treatments. LPN "P" reported that when she missed the treatments it was because she did not have time to complete the treatment. During an interview on 8/15/24 at 10:38 AM, Nurse Supervisor (NS) "C" reported that nurses were supposed to document Resident #27's wound treatment as completed under the "work list" task and then document a wound assessment under the "flowsheet" task in the EHR every day. NS "C" reviewed Resident #27's EHR with surveyor and confirmed that Resident #27 was missing wound care assessments on 7/26/24 through 8/8/24, 7/18/24 through 7/26/24 and 6/29/24 through 7/11/24. NS "C" reported that the facility had started completing wound treatment audits in June, but that Resident #27's missed wound treatments had not been found in the			

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	facility audits. NS "C" reported that she had recently been made aware by Wound Care Nurse "PP" that staff were not completing Resident #27's wound care treatments. NS "C" reported that she was unable to report why the facility staff had missed multiple wound care treatments for Resident #27.			
F0699 SS= D	Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents with a history of trauma received trauma informed care for 1 (Resident #99) from a total sample of 28 residents, resulting in the potential for exposure to trauma triggers and re-traumatization. Findings include: "...According to the National Institute on Mental Health, 2019, "PTSD (Post Traumatic Stress Disorder) is a disorder that some people develop after experiencing a shocking, scary, or dangerous event. It is natural to feel afraid during and after a traumatic situation. This fear triggers many split-second changes in the body to respond to danger and help a person avoid danger in the future. The "fight or flight" response is typical reaction meant to protect a person from harm. Nearly everyone will experience a range of reactions after trauma,	F0699	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Corewell Health Rehabilitation & Nursing Center Kentridge wishes to have this plan of correction stand as its written statement of compliance. F699 Trauma Informed Care Element #1 Resident #99s RCS has been reviewed and updated to include history of past trauma and trauma triggers. Element #2 All residents with a history of trauma residing in the facility as of August 15, 2024 have the potential to be affected. All Care Plans/RCS have been updated to include history of past trauma and trauma triggers. Element #3 The Trauma Informed Care Policy has been reviewed and deemed appropriate by the facility Nursing Home Administrator and Director of Nursing. All Social Workers are registered for and in the process of completing AAPACN	9/19/2024

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	yet most people will recover from those symptoms naturally. Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened even when they are no longer in danger..." https://www.nimh.nih.gov/health/publications/post -traumatic-stress-disorder-ptsd/ptsd-508-0517201. Resident #99 Review of an "Admission Record" revealed Resident #99 was originally admitted to the facility on 11/11/22, with pertinent diagnoses which included: PTSD. Review of Resident #99's "Trauma Assessment" dated 5/11/23 revealed, "Trauma Screening: Have you had any life experience that has interfered with your day-to-day functioning, has caused you distress, and/or has affected you negatively? "Yes", Are there situations, events or other things that may trigger these feelings for you? "Yes"...Trauma Assessment: difficult or stressful event identification: ...transportation accident: "Happened to me"...physical assault: "Happened to me"...Life threatening illness or injury: "Happened to me"...Worst event details: ... (Resident #99 was in a car accident while leaving a bowling alley. She was in a field off the expressway and took an hour for rescue crews to get her out...(Resident #99's) father was also physically abusive..." The document did not indicate what Resident #99's triggers were to these events. Review of Resident #99's "Care Plan" revealed, "Problem: ...actual or potential for mood/behavior impairment related to PTSD: Start: 11/11/21...Interventions: Assess family knowledge of (Resident #99's) mood/behaviors.		Certificate Program for Implementing an IDT Approach to Trauma-Informed Care. All Social Workers will be re-educated on compliance in trauma informed care specifically related to RCS inclusion of past trauma and trauma triggers for residents with history of trauma. All direct care licensed nurses, certified nursing assistants, physical therapists/assistants, occupational therapists, speech therapists, respiratory therapists, and recreational therapists/coordinators will be educated to the inclusion of trauma history and triggers on the Resident Care Summary. Element #4 A quality-assurance program was implemented under the supervision of the Nursing Home Administrator to monitor compliance in trauma informed care of residents with history of trauma. The Nursing Home Administrator or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking of compliance in Care Plans/RCS for residents with history of trauma include past trauma and trauma triggers. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by September 19, 2024. The Administrator is responsible for sustained compliance.	

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COREWELL HEALTH REHAB & NURSING CENTER - KENTRIDGE	**4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508**

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	Assist to identify possible contributing factors. Give (Resident #99) time to express concerns, feelings, fears. Medication: See MAR (medication administration record). Monitor for side effects of psychotropic medications. Mental health services as appropriate. Monitor effectiveness of interventions. Monitor mood/behavior. Document abnormalities. Offer cues, reminders, and clear expectations as needed. Provide education to (Resident #99)/responsible party of potential risks of noncompliant behavior. Provide supportive visits. Prefers to take medication via PEG (feeding tube) hx (history) of catastrophic reactions when offered to take po (by mouth). If (Resident #99) is resistant and aggressive, staff may terminate their task and re-attempt later. Care plan updated so she wakes and gets ready for the day when she wants, has her brief changed as she allows." This was 1 of 2 similar care plan problems. See below. Review of Resident #99's "Care Plan" revealed, "Problem: ...actual or potential mood/behavior impairment related to: History of trauma. Start: 5/10/23...Interventions: Assess family knowledge of (Resident #99's) mood/behaviors. Assist to identify possible support systems, strategies to overcome obstacles. Evaluate behavior for potential contributing factors. Give resident time to express concerns, feelings, fears. Psychotropic Medication: See MAR. Monitor for side effects of psychotropic medications. Mental health services as appropriate. Monitor effectiveness of interventions. Monitor mood/behavior. Document abnormalities. Offer cues, reminders, and clear expectations as needed. Provide education to resident/responsible party of potential risks of noncompliant behavior. Provide supportive visits. See Trauma assessment flow sheet. Guardian endorsed resident having history of past trauma and is triggered by it." There were no triggers indicated.			

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	Review of Resident #99's "RCS (Resident Care Summary: care guide)" revealed, no information related to PTSD and/or past trauma. In an interview on 08/15/24 at 08:33 AM, Nurse Manager (NM) "JJ" reported that Resident #99 had a diagnosis of PTSD, but did not know what the resident's triggers were, based on the information in the care plan and/or the RCS. NM "JJ" reported that the Certified Nursing Assistants (CNA) use the RCS to know how to provide care, including knowing if the resident has past trauma. NM "JJ" reported that Resident #99's RCS did not include history of trauma and/or triggers to past trauma, and the resident's trauma triggers were not listed in the care plan interventions. In an interview on 08/15/24 at 09:23 AM, Social Worker (SW) "L" reported that Resident #99 should have a care plan specifically related to her individual trauma and a list of identified triggers. SW "L" reported that Resident #99's care plan did not list her personal traumatic events, but it indicated to refer to the trauma assessment. In an interview on 08/15/24 at 09:23 AM, SW "D" reported that Resident #99's trauma history was not listed on her RCS, because of general privacy rights, and was not necessary for the CNA to provide care. SW "D" reported that she did not know if the CNA's were familiar with the resident's trauma history, but that they could review her trauma assessment if they wanted to see that information. In an interview on 08/15/24 at 09:46 AM, Certified Nursing Assistant (CNA) "BB" reported that when she is not familiar with a resident, she refers to the RCS for care needs. CNA "BB" reported that she was not aware of Resident #99 having any history of trauma. CNA "BB" referred to the electronic health record and reviewed the			

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	RCS with this surveyor, and confirmed there was no information related to trauma. CNA "BB" reported that she did not know how to access the resident's list of diagnoses, care plan, and did not know where trauma assessments would be located in the record.			
F0880 SS= D	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious	F0880	This plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or conclusion set forth on this statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. Corewell Health Rehabilitation & Nursing Center Kentridge wishes to have this plan of correction stand as its written statement of compliance. F880 Infection Prevention & Control Element #1 Residents #35 and #72 have been reviewed and found to have all Enhanced Barrier Precautions physician orders, Care Plan/RCS documentation, door signage and room PPE supply carts in place. Element #2 All residents residing in the facility as of August 15, 2024 have the potential to be affected. Element #3 The Isolation Precautions Policy has been reviewed and deemed appropriate by the facility Nursing Home Administrator, Director of Nursing, and Infection Prevention Nurse. The Nursing Home Administrator, Director of Nursing, Nurse Educator, and Infection Prevention Nurse have reviewed, confirmed, and deemed appropriate the following	9/19/2024

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	agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to properly implement enhanced barrier precautions for 2 (Resident #35 and Resident #72) of 2 residents sampled for infection control, resulting in the potential for cross contamination and spread of infection. Findings include: Review of "Consideration for the Use of Enhanced Barrier Precautions in Skilled Nursing Facilities", published June 2021, by the Centers for Disease Control and Prevention, revealed: "Residents in skilled nursing facilities are disproportionately affected by multidrug-resistant organism (MDRO) infections ... Resident-to-resident pathogen transmission in skilled nursing		education/orientation: - For direct care licensed nurses and certified nursing assistants: 1. New Employee Orientation and Annual RNC Training: 2024 CHW RNC Annual Regulatory Training Program □□ section 2024 CHW RNC ART Infection Prevention and Control (online learning module) 2. New Employee Orientation Training: PPE Validation Checklist (completed with Nurse Educator during floor orientation) 3. CHCC Orientation Validation Tool (OVT): a. CHCC Orientation Validation Tool (OVT) Rehabilitation & Nursing Centers (RNC) Licensed Nurse b. CHCC Orientation Validation Tool (OVT) Rehabilitation & Nursing Centers (RNC) Unit Aide/Certified Nurse Aide 4. Annual RNC Nursing Skills Fair 2024 (September-October 2024): Identification of residents in isolation precautions and PPE Application validation. - For Physical/Occupational/Speech Team Members: 1. New Employee Orientation and Annual RNC Training: 2024 CHW RNC Annual Regulatory Training Program □□ section 2024 CHW RNC ART Infection Prevention and Control (online learning module) 2. New Employee Orientation Training: Department Orientation Verification Record (DOVR): Rehabilitation Services Employee Orientation Checklist - For Respiratory Therapists: 1. New Employee Orientation and Annual RNC Training: 2024 CHW RNC Annual Regulatory Training Program □□ section 2024 CHW RNC ART Infection Prevention and Control (online learning module) - For Recreational Therapists/Coordinators: 1. New Employee Orientation and Annual RNC Training: 2024 CHW RNC Annual	

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	facilities occurs, in part, via healthcare personnel, who may transiently carry and spread MDROs on their hands or clothing during resident care activities ... Residents who have complex medical needs involving wounds and indwelling medical devices are at higher risk of both acquisition and colonization by MDROs." Resident #35 Review of an "Admission Record" revealed Resident #35, was originally admitted to the facility on 12/28/16 with pertinent diagnoses which included: chronic diastolic heart failure (condition causing decreased blood flow), cellulitis (infection of the skin) of the right lower extremity, peripheral vascular disease (circulatory condition causing narrowing of blood vessels), venous stasis dermatitis (skin inflammation of the lower leg potentially resulting in wounds), blister left leg. Review of a "Minimum Data Set" (MDS) assessment for Resident #35, with a reference date of 5/23/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #35 was cognitively intact. Section "GG" of the MDS revealed Resident #35 required dependent assistance (helper does all the effort) for toileting hygiene, and maximal assistance (helper does more than half the effort) for dressing and transferring out of bed. Review of a facility policy titled "Isolation Precautions for Continuing Care" for all RNC's (corporate name omitted, all skilled nursing facilities) section 4.7 revealed: "Enhanced Barrier Precautions require gown and glove use for certain residents during specific high-contact resident care activities: dressing ...transferring, providing hygiene ...changing briefs ..." Section 4.8 revealed "Enhanced Barrier Precautions will		Regulatory Training Program □□ section 2024 CHW RNC ART Infection Prevention and Control (online learning module) All direct care licensed nurses, certified nursing assistants, physical therapists/assistants, occupational therapists, speech therapists, respiratory therapists, and recreational therapists/coordinators will be re-educated on implementation of Enhanced Barrier Precautions specifically related to following Care Plan/RCS documentation, room signage, and appropriate PPE utilization. Element #4 A quality-assurance program was implemented under the supervision of the Director of Nursing to monitor compliance in implementation of Enhanced Barrier Precautions. The Director of Nursing or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking for implementation of care plans/RCS□, room signage, usage of appropriate PPE for residents with Enhanced Barrier Precautions. Any deficiencies will be corrected on the spot and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Element #5 The facility is confident that these corrective measures will be fully implemented by September 19, 2024. The Administrator is responsible for sustained compliance.	

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	also be implemented when: Resident has wounds ...". Review of a "Resident Care Summary" for revealed Resident #35 occupied bed 2 of her room. A section labeled "Precautions" revealed "7/2/24 at 9:03am, Initiate Enhanced Barrier Precautions (RNC use Only) continuous, Comments: Venous Ulcer". Review of a physician's order dated 7/1/24 at 9:03am, revealed "Initiate enhanced barrier precautions, continuous. Comments: venous ulcer". During an observation on 8/15/24 at 8:47am, signage that read "Enhanced Barrier Precautions" hung outside the door to Resident #35's room, in a holder labeled "Bed 2". During an observation on 8/15/24 at 8:48am, Certified Nursing Assistant (CNA) "R" assisted Resident #35 with grooming while wearing only gloves. In an interview on 8/15/24 at 8:51am, CNA "R" reported she assisted Resident #35 with a brief change, dressing, transfer and grooming and wore gloves while providing the cares but did not wear a gown. When further queried, CNA "R" reported she did not know Resident #35 was in enhanced barrier precautions. In an interview on 8/15/24, at 9:22am, Resident #35 confirmed CNA "R" assisted her with personal hygiene, a brief change, dressing, and donning compression hose on her lower extremities. Resident #35 reported CNA "R" wore gloves but no gown while assisting her. Resident #35 also confirmed she had a wound on her left lower extremity.			

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	Resident #72 Review of an "Admission Record" revealed Resident #72 was originally admitted to the facility on 3/25/23, with pertinent diagnoses which included: bladder obstruction, and multiple skin wounds. Review of Resident #72's "Physician Orders" revealed, "Initiate Enhanced Barrier Precautions...Start 4/3/24"" During an observation and interview on 08/13/24 09:50 AM outside of Resident #72's room there was signage indicating "Enhanced Barrier Precautions". Resident #72 was in his room, sitting in his wheelchair, and there was a catheter bag with urine in it hanging by his side. Resident #72 reported having wounds on his bottom and his legs, and having had a urinary catheter for a long time. Resident #72 reported that he will occasionally get UTI's (urinary tract infections) and wound infections. During an interview on 08/14/24 at 11:40 AM, CNA (Certified Nursing Assistant) "S" reported that Resident #72 had a foley (urinary tract) catheter that the CNA's clean around during incontinence care and also empty the urine from the bag every shift. CNA "S" reported that Resident #72 also had his legs and feet wrapped due to open areas, and a bandage in place on his buttocks. During an observation on 08/14/24 at 01:13 PM, CNA "S" and CNA "HH" were preparing to transfer Resident #72 from his wheelchair to bed, using a mechanical hoyer lift. CNA "S" donned gloves and emptied Resident #72's catheter bag, and discarded the urine in the toilet. CNA "S" did not wear a gown or goggles. CNA "HH" and CNA "S" both donned gloves and proceeded to			

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	transfer Resident #72 from his wheelchair and into his bed, requiring extensive physical manipulation of the resident's upper and lower body to get him centered on the bed as requested. The CNA's were not wearing gowns. In an interview on 08/14/24 at 01:43 PM, CNA "S" reported that she was not aware that Resident #72 had orders for EBP, that he did have a urinary catheter, and that she was thinking that only people that had infections required EBP. CNA "S" reported that she saw the sign, but was confused because the bin of PPE (personal protective equipment) was located on the other side of the hallway. In an interview on 08/14/24 at 01:40 PM, Nurse Supervisor (NS) "C" reported that Resident #72 had multiple wounds that were currently being followed by Wound Nurse (WN) "PP". In an interview via email on 08/14/24 at 1:21 PM, Director of Nursing (DON) "B" reported that Resident #72 had EBP ordered due to having a catheter and wounds.			