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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		414090		B. WING		g		9/23/2024	
NAME OF PROVIDER OR SUPPLIER COREWELL HEALTH REHAB & NURSING CENTER - KENT				STREET ADDRESS, CITY, STA PGE 4118 KALAMAZOO AVE S GRAND RAPIDS, MI 49508			•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ı	ID PREFIX TAG	CORI	CORRECTIVE ACTION SHOULD BE CROSS- COMPLÉ		(X5) COMPLETION DATE	
K0000 SS=	was conducted by of Licensing and of Survey and Cocorewell Health Kentridge was for compliance with participation in M CFR, subpart 48 Fire, and the app 2012 Edition of the Association (NFF)	3, 2024, a Life Safety Revisit by the Michigan Department Regulatory Affairs, Bureau ertification. At the survey, Rehab and Nursing Center und in substantial the requirements for ledicare/Medicaid at 42 3,90(a), Life Safety from buildicable provisions of the ne National Fire Protection PA) 101, Life Safety Code ition of NFPA 99, Health		K0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/14/2024

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.