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 _____	12/5/2024

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

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F0000 SS=	INITIAL COMMENTS Corewell Health Rehab & Nursing Center - Kentridge was surveyed for an Abbreviated Survey from 12/4/24 to 12/5/24. Intakes: MI00146599, MI00146889, MI00147344 Census: 138	F0000		
F0558 SS= D	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake # MI00146599 & MI00146889. Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 2 (Resident #101 and #102) of 3 residents reviewed for accommodation of needs, resulting in the inability to call for staff assistance and the potential for unmet care needs. Findings include: Resident #101 Review of an "Admission Record" revealed Resident #101 was a female, originally admitted to the facility on 1/20/23 with pertinent diagnoses which included age related physical debility. Review of a "Minimum Data Set" (MDS)	F0558		

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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	assessment for Resident #101, with a reference date of 10/23/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 12/15, which indicated Resident #101 had moderate cognitive impairment. Review of Resident #101's current "Care Plan" revealed, "...(Resident #101) does not want to experience a fall with major injury...Interventions...Call light within reach...Start date: 1/21/23..." Review of Resident #101's "Nursing Note" dated 11/1/24 and documented by Nursing Supervisor (NS) "R" revealed, "Had a conversation with (Resident #101) regarding concerns about her call light not being left with her on Saturday 10/26. After speaking with (Resident #101), it was determined that she had her call light clipped to her shirt and called out appropriately for cares to provide to her. She stated that she felt safe and I reminded that we are here is she has any further concerns." Review of Resident #101's "Care Conference Note" dated 11/5/24 revealed, "IDT (Interdisciplinary team) met for scheduled care conferences...(Resident #101) expressed concerns related to her call light and nursing response times. Questions/concerns addressed in the moment. (Resident #101) expressed satisfaction with response/follow up. Will continue to remain available for additional support as needed throughout her stay..." During an observation and interview on 12/4/24 at 12:47 PM, Resident #101 was sitting in her in wheelchair watching television. Resident #101 reported that she had concerns that the facility staff did not ensure that her call light was within reach so that she could call for assistance. Resident #101 reported that she could not get to			

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	her call light if staff did not clip it to her shirt when she was in her wheelchair. Resident #101 reported that she had voiced her concerns about call lights to several staff members at the facility, but she was still experiencing issues with having access to her call light and she did not feel that the facility had resolved her concerns. During an observation and interview on 12/5/24 at 8:36 AM, Resident #101 was sitting in her room in her wheelchair. Resident #101 reported staff had just brought her back to her room from the dining area. Resident #101 reported that she needed assistance from staff, but they had not left her call light within reach. It was noted that Resident #101's call light was hanging on the wall behind her, and out of reach. During an observation and interview on 12/5/24 at 8:42 AM, Registered Nurse (RN) "L" entered Resident #101's room with this writer and confirmed that Resident #101's call light was out of her reach. During an interview on 12/5/24 at 11:15 AM, Certified Nursing Assistant (CNA) "W" reported that she was the staff member that had assisted Resident #101 back to her room earlier in the morning. CNA "W" reported that she had forgotten to place Resident #101's call light within her reach. CNA "W" confirmed that she was aware that Resident #101 required a call light to be attached to her shirt so that she could use it to call for staff assistance. During an interview on 12/5/24 at 9:51 AM, NS "R" reported that she was aware that Resident #101 had ongoing concerns related to her call light. NS "R" reported that she had been made aware on 11/1/24 that Resident #101 had reported her call light being left out of her reach on 10/26/24. NS "R" confirmed that she was not able			

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	to verify that Resident #101 had her call light in reach on 10/26/24 because she did not make any observations, but that when she met with Resident #101 on 11/1/24 that Resident #101's call light was in reach that day. NS "R" reported that she had not completed any audits after she spoke with Resident #101 on 10/26/24 to confirm that staff were continuing to place Resident #101's call light within in her reach. NS "R" confirmed that facility staff were expected to ensure residents had call lights placed within reach. Review of the facility's "Call light Accessibility, Use, and Response" policy dated 9/23/22 revealed, "Purpose: The purpose of this policy is to ensure each resident call light is accessible, functional for use and responded to appropriately...Policy...With each interaction in the resident's room, bathroom, or bathing facility team members will ensure the call light is within reach of resident and secured as needed..." Resident #102 Review of a "Face Sheet" revealed Resident #102 was a male, with pertinent diagnoses which included PTSD (Post-Traumatic Stress Disorder), TBI (Traumatic Brain Injury), anxiety, chronic pain, depression, and seizures. Review of a current "Care Plan" for Resident #102 revealed the problem "...at risk for communication deficits related to cognitive communication deficits..." with a start date of 8/4/22, and interventions which included "...Specialized call light..." Review of a current "Care Plan" for Resident #102 revealed the problem "...at risk for falls or injury..." with a start date of 8/4/22, and interventions which included "...Call light within reach..."			

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	Review of a "Resident Care Summary" (RCS) for Resident #102 revealed "...Encourage Patient to use pillows for positioning and to have call light placed on left side near hip..." dated 10/28/24. In an observation on 12/5/24 at 9:03 AM, Resident #102 was noted in a specialty reclining wheelchair in his room. Observed Resident #102's specialized call light was out of reach, clipped to the cord on the wall several feet behind his wheelchair. In an observation on 12/5/24 at 9:13 AM, Resident #102 was noted in a specialty reclining wheelchair in his room. Observed Resident #102's specialized call light was out of reach, clipped to the cord on the wall several feet behind his wheelchair. In an observation on 12/5/24 at 9:33 AM, "Certified Nursing Assistant" (CNA) "U" assisted Resident #102 with a transfer from his specialty wheelchair to his bed. Once Resident #102 was in bed, observed CNA "U" place his specialized call light on the blanket, near Resident #102's right shoulder. In an interview on 12/5/24 at 9:42 AM, CNA "U" reported nursing staff reference the "Resident Care Summary" (RCS) to determine how to care for a resident and specific/individualized care needs. In an observation and interview on 12/5/24 at 11:46 AM, Resident #102 was noted in a specialty reclining wheelchair in his room. Observed Resident #102's specialized call light was out of reach, clipped to the cord on the wall several feet behind his wheelchair. Family Member "N" present at this time, and reported a concern that the nursing staff do not always check the "computer" (RCS) prior to caring for Resident			

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	#102. In an observation on 12/5/24 at 1:49 PM, Resident #102 was noted in a specialty reclining wheelchair in his room. Observed Resident #102's specialized call light was out of reach, clipped to the cord on the wall several feet behind his wheelchair. In an observation on 12/5/24 at 2:08 PM, Resident #102 was noted in bed in his room. Observed Resident #102's specialized call light was clipped to the blanket near his right shoulder. In an interview on 12/5/24 at 2:12 PM, CNA "U" reported no specific placement was required for Resident #102's specialized call light. CNA "U" stated "...I just try and clip it somewhere close to him..."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake # MI00146599. Based on observation, interview, and record review, the facility failed to ensure showers were provided per resident preference and plan of care for 1 (Resident #101) of 3 resident reviewed for "Activities of Daily Living" (ADL) care, resulting in inadequate personal hygiene, missed showers, and dissatisfaction with care and hygiene concerns.	F0677		

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	Findings include: Resident #101 Review of an "Admission Record" revealed Resident #101 was a female, originally admitted to the facility on 1/20/23, with pertinent diagnoses which included age related physical debility. Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 10/23/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 12/15, which indicated Resident #101 had moderate cognitive impairment. Review of Resident #101's current "Care Plan" revealed, "(Resident #101) requires assistance with ADL's...Interventions...Showers as scheduled...Start date: 2/7/24..." Review of Resident #101's "Daily Cares" revealed that Resident #101 did not have documentation of any showers or baths provided on the following scheduled shower dates: 10/19/24, 10/26/24, 11/13/24, 11/16/24, and 11/20/24. During an observation and interview on 12/4/24 at 12:47 PM, Resident #101 was sitting in her wheelchair in her room. Resident #101 reported that she had concerns with the facility staff not assisting her with showers on her scheduled shower days. Resident #101 reported that she was scheduled to have showers on Wednesdays and Saturdays, but she was not consistently getting two showers a week. During an interview on 12/5/24 at 9:51 AM, Nursing Supervisor (NS) "R" reviewed Resident #101's Electronic Health Record (EHR) with this			

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	writer and confirmed that Resident #101 did have any documentation to verify that Resident #101 had received or refused showers or a bath on 10/19/24, 10/26/24, 11/13/24, 11/16/24, and 11/20/24. NS "R" reported that she was not aware that Resident #101 had missed multiple showers. NS "R" confirmed that Certified Nursing Assistants (CNA's) were responsible for documenting that they had provided showers for residents. NS "R" reported that nurses were responsible for completing skin assessments on resident's shower days, but that documentation of nursing skin assessments did not indicate that a shower had been completed. On 12/5/24 at 2:02 PM, Director of Nursing (DON) "B" provided additional CNA documentation for Resident #101's showers. It was noted that the CNA documentation did not include documentation for showers or refusals for Resident #101 on 10/19/24, 10/26/24, 11/13/24, 11/16/24, and 11/20/24. On 12/5/24 at 3:57 PM, DON "B" provided "Nursing Skin Assessments" for Resident #101 for the following dates: 10/19/24, 10/26/24, 11/17/24, & 11/20/24. It was noted that each nursing skin assessment did not note that a shower was provided for Resident #101. During an interview on 12/5/24 at 4:03 PM, Registered Nurse (RN) " L" reported that nurses were responsible for completing skin assessments for residents on their scheduled shower days. RN "L" reported that nurses would typically complete the skin assessment right before of after the resident's shower, but that they were required to complete the assessment even if the resident missed the shower. RN "L" confirmed that documentation of a nursing skin assessment would not indicate that a resident had received a shower unless it was noted that the resident had			

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	received a shower. During an interview on 12/5/24 at 4:12 PM, RN "GG" reported that nurses were responsible for completing skin assessments on resident's scheduled shower days. RN "GG" reported that if the nurse had completed the skin assessment during the resident's shower, that they would document that the shower was completed in their skin assessment note. RN "GG" reviewed the skin assessment notes for Resident #101 on 10/19/24, 10/26/24, 11/17/24, & 11/20/24 with this writer and reported that the notes did not indicate that a shower had been completed.			