

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/12/2025
NAME OF PROVIDER OR SUPPLIER  Corewell Health Rehab & Nursing Center - Kentridge		STREET ADDRESS, CITY, STATE, ZIP CODE  4118 Kalamazoo Ave S E Grand Rapids, MI 49508	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955</b></p> <p>Based on observation, interview, and record review the facility failed to maintain proper infection control practices as evidenced by failure to 1. Ensure proper hand hygiene was completed during incontinence care for 1 (Resident #14); and 2. Ensure proper PPE (personal protective equipment) for enhanced barrier precautions was used during personal cares for 1 (Resident #14) of 15 total sampled residents reviewed for infection control practices resulting in the potential for the introduction of infection, cross-contamination, and/or disease transmission.</p> <p>Findings include:</p> <p>Resident #14</p> <p>Review of a Face sheet revealed Resident #14 was male and was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Traumatic brain injury (TBI; a brain injury that occurs when a sudden external physical assault happens to the brain), dysphagia (difficulty or the inability to swallow), and neurogenic bladder (a lack of coordination between the brain and the bladder resulting in the inability to feel the bladder is full, urine leakage, and urinary incontinence.)</p> <p>On 3/10/25 at 11:45 a.m. a sign was observed posted on the wall outside of Resident #14's room indicated that Resident #14 was in enhanced barrier precautions (EBP).</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/10/25 at 11:50 a.m. this surveyor entered Resident #14's room and observed Rehab Tech/Certified Nurse Assistant (RT/CNA) O kneeling beside Resident #14's bed emptying Resident #14's urinary catheter bag (a closed drainage bag that collects urine from a catheter inserted into the bladder) of urine. RT/CNA O was wearing gloves but was not wearing a gown. RT/CNA O reported she was assisting Resident #14 with a bed bath and to get dressed for the day. RT/CNA O was then observed opening cupboards and drawers around the room locating supplies, wetting down washcloths in the sink in the bathroom, and washing Resident #14's face and hands. RT/CNA O wore the same pair of gloves she was wearing when she emptied the catheter bag. At 12:02 RT/CNA applied clean gloves and continued to provide bathing assistance to Resident #14. RT/CNA O was then observed retrieving the dirty linen cart from the bathroom and placing it closer to the bedside while wearing the same pair of gloves. RT/CNA O then retrieved a washcloth from the bed, wet it down in the wash basin at the bed side and continued Resident #14's bed bath. RT/CNA O then retrieved more washcloths from the cupboard with gloved hands and returned to the bedside and continued Resident #14's bed bath. RT/CNA reported Resident #14 had a daily schedule for being out of bed and resting, and RT/CNA walked to the cupboard in Resident #14's room, opened it to reveal Resident #14's schedule on the inside of the door. RT/CNA O then returned to the bedside and removed Resident #14's gown and continued his bed bath. RT/CNA O was still wearing the same gloves. RT/CNA O completed Resident #14's bed bath, assisted Resident #14 to be dressed, and placed a sling under Resident #14 for transfer; RT/CNA O then removed her gloves, sanitized her hands and exited the room. At 12:09 p.m. RT/CNA O re-entered Resident #14's room, cleaned up the dirty linen, wash basin and bed bath supplies and completed a mechanical lift transfer of Resident #14 from his bed to his wheelchair, adjusted Resident #14's clothing and body position for comfort in his wheelchair. At no time after re-entering the room did RT/CNA O sanitize her hands or wear any kind of PPE (gown or gloves). At 12:13 p.m. RT/CNA O donned (put on) a pair of gloves and applied Resident #14's hand splints to both hands, made Resident #14's bed, opened the window cover, straightened up the room, and applied lip balm to Resident #14's lips. RT/CNA O did not change gloves or perform hand hygiene between these observed tasks.</p> <p>Review of Enhanced Barrier Precautions signage posted outside of Resident #14's room revealed wear gown and gloves for all high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs/assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing.</p> <p>In an interview on 3/10/25 at 12:20 p.m. RT/CNA O reported that the signage outside of Resident #14's room indicated he was in enhanced barrier precautions and that she should have worn gloves and a gown during the cares she performed.</p> <p>Review of Other Order for Resident #14 initiated on 4/3/2024 revealed initiate enhanced barrier precautions continuous.</p> <p>On 3/10/25 at 2:38 p.m. RT/CNA N was observed wearing gloves as she applied Resident #14's splint to his bilateral arms. RT/CNA was noted to be leaning over the bed and within close proximity to resident during the application of hand splints. RT/CNA N was observed positioning Resident #14 in bed, with his splints in place and pillows for comfort. RT/CNA N did not wear a gown during cares. RT/CNA N reported that enhanced barrier precautions meant that staff needed to wear a gown and gloves when providing care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/10/25 at 2:53 p.m. CNA R reported that enhanced barrier precautions were put into place for residents who had tubes, lines, or drains such as G-tube. (a tube placed directly into the stomach and used for nutrition, hydration, and medication administration) and a foley catheter. CNA R reported the staff needed to wear a gown and gloves when providing high contact care, such as a bed bath or incontinence care.</p> <p>In an interview on 3/10/25 at 2:56 p.m. CNA DD reported that enhanced barrier precautions were put in place for residents with tube feedings. (G-tubes) and staff needed to wear a gown and gloves when in the room.</p> <p>On 3/11/25 at 2:54 p.m. this surveyor entered Resident #14's room and observed CNA FF and CNA DD preparing to transfer Resident #14 via a mechanical lift (the sling under Resident #14 was already connected to the lift) from his wheelchair into his bed. Neither CNA FF nor CNA DD were wearing a gown. CNA FF transferred Resident #14 to bed, removed the sling from under him, and removed his pants. CNA FF then removed Resident #14's brief and found it to be soiled with bowel movement (BM). CNA FF took washcloths to the bathroom sink to wet them down and performed peri-care for Resident #14. During peri-care, CNA FF asked CNA DD to retrieve a towel from the cupboard, which she did with gloved hands. CNA FF then wet down the corner of the towel in the sink and finished cleaning Resident #14's buttock of BM. CNA FF then used the other end (the dry part) of the towel to dry Resident #14's buttock. CNA DD wore the same pair of gloves through the observation.</p> <p>In an interview on 3/11/25 at 3:06 p.m. CNA FF reported every person on the unit was on enhanced barrier precautions for their G-tubes. CNA FF reported that enhanced barrier precautions were only for the nurses when they were working with the G-tubes, it did not apply to the CNAs. When queried CNA FF stated No, I don't wear a gown for residents in EBP when I provide care.</p> <p>In an interview on 3/12/25 at 10:14 a.m. LTC Nurse Supervisor (LTC/NS) F reported enhanced barrier precautions were used for open wounds, foley catheters, and G-tubes, to prevent the spread of bacteria. LTC/NS F reported that a gown and gloves needed to be worn when the staff was in the room to care for the wound, catheter, or the G-tube and the staff should wear it during a transfer.</p> <p>In an interview on 3/12/25 at 10:20 a.m. Infection Preventionist (IP) E reported staff was to wear a gown and gloves when performing high contact care activities with residents who were in enhanced barrier precautions. IP E reported CNAs should wear a gown when performing peri-care, transfers, and emptying foley catheters and nurses should wear a gown and gloves when working with a G-tube.</p> <p>In an interview on 3/12/25 at 10:30 a.m. Director of Nursing (DON) B reported her expectations were that the staff followed the signage posted outside of the resident's room prior to entering and providing care.</p> <p>Review of facility policy Isolation Precautions for Continuing Care- Rehab and Nursing Centers with a last revision date of 7/10/2024 revealed .Enhanced Barrier Precautions require gown and glove use for certain residents during specific high-contact resident care activities that have been found to increase MDRO (multi-drug resistant organism) transmission such as .dressing, bathing/showering, transferring, providing hygiene, changing briefs .device care or use: . feeding tube .enhanced barrier precautions will also be implemented when Resident has wounds and/or indwelling medical devices (e.g. central line, urinary catheter, feeding tube .) regardless of MDRO colonization status.</p>		