STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235035	A. Building B. Wing	08/15/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 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 [DATE] with pertinent diagnoses which included vascular dementia without behavioral disturbance. Review of Resident #84's Orders revealed Hydrocodone-acetaminophen (norco) (opioid 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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 . 46999 Resident #44 Review of an Admission Record revealed Resident #44, was originally admitted to the facility on [DATE] 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) 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 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #74, was originally admitted to the facility on [DATE] 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. 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.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 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: Resident #27 Review of an Admission Record revealed Resident #27 was originally admitted to the facility on [DATE] 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. Review of Resident #27's Wound assessment dated [DATE] revealed, wound length: 0.3 cm, wound width 0. 2 cm, wound depth 0.2 cm . Review of Resident #27's Wound assessment dated [DATE] 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 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, 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 [DATE], with pertinent diagnoses which included: PTSD. Review of Resident #99's Trauma assessment dated [DATE] 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. 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. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 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 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 [DATE] 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41027 Resident #72 Review of an Admission Record revealed Resident #72 was originally admitted to the facility on [DATE], 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.