Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235075	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corewell Htlh Gr Hosps Rehab & Nsg Ctr-1226cedarst	1226 Cedar St NE Grand Rapids, MI 49503

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00142952. Based on interview and record review, the facility failed to report an allegation of neglect facility staff did not follow a resident care plan to prevent falls to the State Agency for 1 of 3 residents (Resident #103) reviewed for falls, resulting in the potential for continued violations involving neglect and/or abuse going undetected, unreported, or without thorough investigation. Findings include: Review of Resident #103's Care Plan revealed, Problem: .at risk for falls: Start Date: 10/24/23 . INTERVENTIONS: .See Resident Care Summary (RCS) .PROBLEM: .requires assistance with mobility. Start Date: 10/24/23 .INTERVENTIONS: .See RCS. Review of Resident #103's RCS revealed, .Transfer: Dependent: Lift - Sit to Stand. Review of Resident #103's Fall Report dated 10/29/24 at 3:15 PM revealed, .IDT (interdisciplinary team) met and reviewed a witnessed/assisted fall where the POC (plan of care) was not followed. CNA (Certified Nursing Assistant) was transferring resident from bed to his wheelchair without checking the RCS instead just asking the resident how he transferred. CNA stood the resident up and began sitting him down when she noted that he was not sitting back enough and would fall. She quickly called for help from the nurse where they were able to assist the resident to the ground being unable to guide him back further into the wheelchair . In an interview on 6/28/24 at 3:20 PM, Licensed Practical Nurse (LPN) E reported that she responded to CNA M's yell for help with Resident #103 on 10/29/23. LPN E reported that when she entered Resident #103's room, he was half on his wheelchair and half on the bed. LPN E reported that Resident #103 was falling. An attempt was made on 6/28/24 at 3:29 PM to interview CNA M regarding Resident #103's fall, but no return call was received prior to survey exit. In an interview on 6/28/24 at 4:00 PM, NHA (Nursing Home Administrator) A reported that CNA M did not follow Resident #103's care plan for transfer needs, which resulted in a witnessed fall on 10/29/23. NHA A reported that she did not report the violation to the State Agency. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Corewell Htlh Gr Hosps Rehab & Nsg Ctr-1226cedarst		STREET ADDRESS, CITY, STATE, ZIP CODE 1226 Cedar St NE Grand Rapids, MI 49503	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Resident Abuse Porgram Procedure dated 10/30/23 revealed, . Reporting/response 11.1. All allegations and substantiated incidents will be reported, analyzed, and responded to with corrective actions to prevent further or repeated situations from occurring. 11.2. Any allegation, even if it does not seem credible, or if the resident is known to make frequent, unsubstantiated allegations, must be reported. 11.3. When abuse, neglect or exploitation is suspected, follow the appropriate steps: 11.3.1. [NAME] reporting: In compliance with Federal law, an immediate report is provided to the Administrator/designee and the State Survey Agency ([NAME]) of alleged violations involving physical, mental, involuntary seclusion and sexual abuse, as well as neglect, mistreatment, misappropriation, and injuries of unknown origin. The Administrator/designee must report to [NAME] within two hours. The initial report must provide sufficient information to describe the alleged violation and indicate how the residents are being protected .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00142952 Based on interview, and record review, the facility failed to implement care plan interventions, and perform safe transfers in 1 of 3 residents (Resident #103) reviewed for falls, resulting in a fall and the potential for harm. Findings include: Review of a Face Sheet revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: weakness, chronic pain of both lower extremities, and left foot fracture. Review of Resident #103's Fall Risk assessment dated [DATE] indicated a moderate risk for falls. In an interview on 6/28/24 at 8:43 AM, Family Member F reported that Resident #103 admitted to the facility on [DATE] for rehabilitation following a fall at home where he had fractured his foot. Review of Resident #103's Care Plan revealed, Problem: .at risk for falls: Start Date: 10/24/23 . INTERVENTIONS: .See Resident Care Summary (RCS) .PROBLEM: .requires assistance with mobility. Start Date: 10/24/23 .INTERVENTIONS: .See RCS. Review of Resident #103's RCS revealed, .Transfer: Dependent: Lift - Sit to Stand. Review of Resident #103's Fall Report dated 10/29/24 at 3:15 PM revealed, .IDT (interdisciplinary team) met and reviewed a witnessed/assisted fall where the POC (plan of care) was not followed. CNA (Certified Nursing Assistant) was transferring resident from bed to his wheelchair without checking the RCS instead just asking the resident how he transferred. CNA stood the resident up and began sitting him down when she noted that he was not sitting back enough and would fall. She quickly called for help from the nurse where they were able to assist the resident to the ground being unable to guide him back further into the wheelchair . Review of Resident #103's Nurse Note dated 10/29/23 at 3:41 PM revealed, Witnessed fall .CNA transferring resident to wheelchair, he sat on edge of wheelchair, cna called for help, nurse came and both cna and nurse tied to sit resident back in wheelchair without success, resident was lowered to the ground in a sitting position against wheelchair . In an interview on 6/28/24 at 3:20 PM, Licensed Practical Nurse (LPN) E reported that she responded to CNA M's yell for help with Resident #103 on 10/29/23. LPN E reported that when she entered Resident #103's room, he was half on his wheelchair and half on the bed. LPN E reported that Resident #103 was falling. An attempt was made on 6/28/24 at 3:29 PM to interview CNA M regarding Resident #103's fall, but no return call was received prior to survey exit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/28/24 at 4:00 PM, NHA (Nursing Home Administrator) A reported that CNA M did not follow Resident #103's care plan for transfer needs, which resulted in a witnessed fall on 10/29/23.