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	11/21/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 Based on observation, interview, and record review, the facility failed to promote dignity during meals and ensure residents are treated with respect in 3 of 5 residents (Resident #13, #56, & #21) reviewed for dignity/respect, resulting in the potential for feelings of embarrassment, frustration, and impaired self-worth. Findings include: Time management, therapeutic communication, patient education, and compassionate implementation of bedside skills are just a few of the essential skills you need. It is important for your patients to leave the health care setting with a positive image of nursing and a feeling that they received quality care. Your patients should never feel rushed. They need to feel that they are important and are involved in decisions and that their needs are met. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 1589-1592). Elsevier Health Sciences. Kindle Edition. In an interview on 11/19/24 at 11:04 AM, Confidential Information (CI) CC reported in the dining room, staff often are .just talking amongst themselves . and .feeding people too quickly . Resident #13 Review of a Face Sheet revealed Resident #13 was a male, with pertinent diagnoses which included dementia, diabetes, and depression. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 10/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated moderate cognitive impairment. Review of a current Care Plan for Resident #13 revealed the problem .at risk for Altered Nutrition and Hydration .(related to) self-feeding deficits . In an observation on 11/19/24 at 12:58 PM, Certified Nursing Assistant (CNA) O assisted Resident #13 with his lunch meal. Observed Resident #13 seated in a wheelchair at a table in the corner of the main dining room. CNA O stood beside Resident #13, offering large spoonfuls of his lunch meal. Noted CNA O did not speak/interact with Resident #13 while providing assistance with the lunch meal. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56 Review of a Face Sheet revealed Resident #56 was a female, with pertinent diagnoses which included dementia, depression, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #56, with a reference date of 8/8/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. Review of a current Care Plan for Resident #56 revealed the problem .at risk for altered nutrition and hydration status .(related to) self-feeding deficits . In an observation on 11/19/24 at 1:15 PM, Certified Nursing Assistant (CNA) O approached Resident #56 in the main dining room to assist her with her lunch meal. CNA O stood beside Resident #56, quickly offering large bites of the lunch meal. Noted CNA O did not speak/interact with Resident #13 while providing assistance with the lunch meal. In an interview on 11/19/24 at 1:30 PM, CNA O stated in regard to the decision to sit or stand when providing meal assistance to residents, it .depends on if I feel like standing up or sitting down . In an interview on 11/19/24 at 1:32 PM, CNA K reported staff should sit down at the table beside the resident when providing meal assistance. 41027 Resident #21 Review of an Admission Record revealed Resident #21 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke (damage to brain causing paralysis of left side of body). Review of a Minimum Data Set (MDS) assessment for Resident #21, with a reference date of 9/27/24 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #21 had moderate cognitive impairment. In an interview on 11/19/24 at 02:21 PM, Resident #21 reported that he had his call light on so that he could get help to go to bed. Resident #21 reported that he had told staff earlier, but they never came back. Resident #21 reported that staff treat him badly, and when he asks for things they ignore him or make excuses. In an observation on 11/19/24 at 2:25 PM in Resident #21's room, Certified Nursing Assistant (CNA) E entered the room and turned the call light off. Resident #21 requested to go to bed, and CNA E said that she would have to go find a lift machine, and left the room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/21/24 at 09:05 AM, in the hallway near Resident #21's room, Resident #21 reported that the staff in the dining room ignored him when he asked them to bring him his hot cocoa, and that he sat there as long as he could waiting for it. Resident #21 presented his breakfast order ticket to this surveyor, and hot cocoa was listed on the ticket. At 09:07 AM in the hallway, Resident #21 was observed asking dietary staff to get him his hot cocoa. The dietary staff stated that they would have to check on it, and walked away. In an interview on 11/21/24 at 09:09 AM, Restorative Aide (RA) JJ reported that she was assisting residents in the dining room earlier that morning. RA JJ reported that Resident #21 was on a fluid restriction and that may have been why he could not have hot cocoa. In an interview on 11/21/24 at 10:52 AM, Nurse Manager (NM) KK reported that Resident #21 was not on a restricted fluid diet, and should be able to have hot cocoa as requested. During an observation on 11/21/24 at 09:35 AM Resident #21's call light was on, and his roommate exited the room requesting assistance for Resident #21. Then Registered Nurse (RN) F was observed talking to Resident #21. Resident #21 requested to use the toilet and lay down, to which RN F replied that they would need to find help and in the meantime would turn the call light off. Resident #21 then replied loudly, No, leave the light on! At 09:39 AM an unknown CNA asked Resident #21 what he needed, and the resident replied again they he needed help to use the toilet and lay down in bed, to which the CNA told him that she would have to get a lift machine, and walked away. At 09:41 AM a different CNA, CNA H was walking towards Resident #21's room and stated, What's your problem .do you want to go to bed? CNA H proceeded to assist Resident #21 to the toilet, and asked him if he was having a good day. Resident #21 became agitated and said No! CNA H replied by referring to him as Honey and said that he should calm down, be more positive, and that she could solve all of his problems. Then CNA H told Resident #21 that she wanted to be sure that he didn't need anything else before she helped him to bed and stated, .after I leave I don't want you to be calling for this and that . Resident #21 did not reply and was observed to shake his head in a frustrated way. During an observation and interview on 11/21/24 at 10:00 AM, Resident #21 was lying in bed, and reported that the way CNA H had treated him was typical and that he didn't feel like he mattered to them. Resident #21's fingernails on his left hand were long and dirty, with a bandage covering the ring finger nail. Resident #21 reported that staff at the dialysis clinic applied the bandage a long time ago because his nails dug into his hand and made it bleed. Resident #21 reported that that finger was tender to touch. In an interview on 11/21/24 at 10:09 AM, Licensed Practical Nurse (LPN) U reported that she was not aware that Resident #21 had a Band-Aid on his finger, and that she did not see anything in his chart about it. LPN U entered Resident #21's room and asked the resident about his finger. Resident #21 tried to explain, but LPN U kept interrupting and asking him questions. Resident #21 stated, Listen to me! Then LPN U's phone rang, and she answered the phone at the beside. After the phone call was finished, LPN U walked away from the resident, and reported to this surveyor that the resident did not know anything about the Band-Aid, but that it looked old. Then Resident #21 asked LPN U to come back so that he could explain to her what the Band-Aid was.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to provide assistance with fingernail grooming/hygiene for 2 of 5 residents (Resident #21 and #19) reviewed for activities of daily living (ADL's), resulting in the potential for diminished dignity, alteration in skin integrity, nail infection. Findings include: Resident #21 Review of an Admission Record revealed Resident #21 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke (damage to brain causing paralysis of left side of body). Review of a Minimum Data Set (MDS) assessment for Resident #21, with a reference date of 9/27/24 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #21 had moderate cognitive impairment. Reveiw of Resident #21's Care Plan with a 9/16/21 start date revealed, .requires assistance with ADLs related to chronic disease progression r/t (related to) comorbidities, fatigue, weakness . In an interview on 11/19/24 at 02:21 PM, Resident #21 reported that staff treat him badly, and when he asks for things they ignore him or make excuses. In an observation on 11/19/24 at 2: 25 PM Resident #21's fingernails on his right hand were long and dirty, his left hand was closed tightly, and his nails were not visible. In an interview on 11/19/24 at 02:29 PM, Certified Nursing Assistant (CNA) E reported that she had given Resident #21 a shower that morning, but did not clean or trim his nails. CNA E reported that it was the first time taking care of Resident #21, and that staff in the dining room should be cleaning his hands. During an observation on 11/20/24 at 03:23 PM, Resident #21's fingernails were still long on his right hand, but were shorter than the day before. During an observation and interview on 11/21/24 at 10:00 AM, Resident #21 was lying in bed, and the fingernails on his left hand were long and dirty, with a bandage covering the ring finger nail. Resident #21 reported that staff at the dialysis clinic applied the bandage a long time ago because his nails dug into his hand and made it bleed. Resident #21 reported that that finger was tender to touch. Resident #21 reported that he would like all of his nails to be shorter. In an interview on 11/21/24 at 10:09 AM, Licensed Practical Nurse (LPN) U reported that she was not aware that Resident #21 hand a Band-Aid on his finger, and that she did not see anything in his chart about it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/21/24 at 10:18 AM, CNA P reported that he had cared for Resident #21 frequently, but had not noticed a Band-Aid on his finger. CNA P reported that Resident #21 preferred to cut his own nails, and refused staff assistance. CNA P reported that he did not know what he was supposed to do if Resident #21 refused cares. In an interview on 11/21/24 at 10:52 AM, Nurse Manager (NM) KK reported that there was no record of Resident #21 having any issues with his left ring finger. In an interview on 11/21/24 at 11:13 AM, Nurse Supervisor (NS) D reported that she had just then visited with Resident #21, and that his fingernail was thick and tender to touch, and that the resident had requested to have a professional cut the nail for him. NS D reported that she would arrange for the services. Resident #19 Review of Resident #19's Care Plan with a start date of 9/20/21 revealed, .requires assistance with ADLs r/t TBI (traumatic brain injury) with left hemiparesis (paralysis) . During an observation on 11/19/24 at 02:00 PM in Resident #19's room, Resident #19 was lying in bed. Resident #19's fingernails were very long and dirty. In a subsequent interview on 11/19/24 at 2:15 PM, LPN T reported that Resident #19 was completely dependent on staff for all care, and should have regular nail care done during his bed baths, but that she had thought the CNA's reported refusals. In an interview on 11/20/24 at 03:18 PM, LPN T reported that Resident #19 had allowed her to cut his nails that day, and they were now short and clean.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to ensure that thorough documentation of a death in the facility was completed and fingernail issues were recorded for 1 of 23 residents (Resident #113) reviewed for accurate and complete medical records, resulting in insufficient details related to death in the facility for Resident #113. Findings include: Resident #113 Review of Resident #113's Flow Sheets dated [DATE] at 5:11 AM indicated, date of death [DATE] at 4:25 AM. Review of Resident #113's discharged as deceased Summary dated [DATE] at 12:13 PM revealed, .history of stroke, .multiple hospitalization s for sepsis and infections and progressive decline in the nine months preceding his passing. He passed away on [DATE] . Review of Resident #113's Nurse's Note dated [DATE] at 5:36 AM revealed, Contacted resident's daughter via phone. Explained to her what happened. She became very upset and hang (sic) up. Will try to call her back to get information. In an interview on [DATE] at 01:08 PM, Nurse Supervisor (NS) N reported that she was not certain of the details of Resident #113's death in the facility. In an interview on [DATE] at 01:27 PM, NS G reported that she did not know Resident #113 and that the medical record did not indicate how he had passed away, there was not a nurse's note describing how/where the resident was found, or the condition he was in prior to his passing. In an interview on [DATE] at 01:56 PM, Nurse Manager (NM) C reported that a nurse's note is not typically written when a resident passed away. In an interview on [DATE] at 02:20 PM, Director of Nursing (DON) B reported that there was no documentation related to Resident #113's death, but that she was told that he passed away peacefully in the night. DON B reported that the facility had a policy in place related to the documentation of death, and that a nursing narrative note should have been created.