STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235205	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corewell Health Reed City Hospital Rehabilitation	300 North Patterson Road Reed City, MI 49677

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain the kitchen/facilities equipment and fixtures so that they were clean, sanitary and in proper working order, potentially affecting all residents that receive food from the kitchen.Findings include: The following observations were observed on 12/02/25 from 10:15 AM to 11:20 AM, during the initial tour of the kitchen/facility with Prep [NAME] (PC) J.Observation of the cook line hand sink (on the wall closest to the hood system) was observed to be missing the proper signage. Also, hangers/clips were being used to hang/store dirty dustpan and broom equipment on the wall adjacent and level to the hand sinks basin.Review of the FDA 2017 Food Code Section, 6-301.14 Handwashing Signage Reflects the following, A sign or poster that notifies FOOD EMPLOYEES to wash their hands shall be provided at all HANDWASHING SINKS used by FOOD EMPLOYEES and shall be clearly visible to FOOD EMPLOYEES.Review of the FDA 2017 Food Code Section, 6-501.113 Storing Maintenance Tools Reflects the following, Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be: (A) Stored so they do not contaminate FOOD, EQUIPMENT, UTENSILS, LINENS, and SINGLE-SERVICE and SINGLE USE ARTICLES;Observation of the can opener blade and the drip line of the housing unit (located beneath the can opener blade) were observed to have a build-up of a black sticky substance.Observation of a pinkish-orange slime on the ice deflector shield was observed inside the ice machine located inside the kitchen.Review of the FDA 2017 Food Code Section, 4-602.11 Equipment Food-Contact Surfaces and Utensils Reflects the Following, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: (5) At any time during the operation when contamination may have occurred. (E) Except when dry cleaning methods are used as specified under 4-603.11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not POTENTAILLY HAZARDOUS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be cleaned: (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil tanks and distribution lines, Beverage and syrup dispensing lines or tubes, coffee bean grinders and water vending equipment: (b) Absent of manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.Observation of the cook line prep cooler revealed a build-up of food residues, debris and grime on the doors, door seals, opening, and bottom of the unit. Review of the FDA 2017 Food Code Section, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. Reflects the following, (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of accumulation of dust, dirt, FOOD residue, and other debris.Observation of the Ice machine area reflected a tag (labeled New Filter) hanging from the water filter for the ice machine. The dates on the tag reflected the filter had been replaced on 3/22/24 and 6/11/24. No current dates were observed. Observation of the water filter for the coffee and juice machine area reflected a date of 6/23.Review of the FDA 2017 Food Code Section, 5-205.13 Scheduling Inspection and Service for a Water System Device. Reflects the following, A device such as a water treatment device or backflow preventer shall be scheduled for inspection and service, in accordance with manufacturer's instructions and as necessary to prevent (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	device failure based on local water conditions, and records demonstrating inspection and service shall be maintained by the PERSON IN CHARGE.During the kitchen observation, wiping cloth towels were being used to move pots, pans and sheet pans to and from the oven and stove instead of potholders. The towels being used were observed to be thin and had loose threads hanging. This surveyor became concerned when the towel with the hanging threads came close to the open flame on gas stove while staff was adjusting a pot. During this observation Kitchen Employee ([NAME]) I revealed, we are now using our wiping cloth towels as potholders because we were told that's what real kitchens do. The towels/wiping cloths are not designed for this purpose. The potential for the towels catching on fire and the increased likely hood of staff burning themselves increases significantly because of their design and misuse.Review of the FDA 2017 Food Code Section, 4-102.11 Characteristics Reflects the following, Materials that are used to make SINGLE-SERVICE and SINGLE USE ARTICLES: (A) May not: (1) Allow the migration of deleterious substances, . (B) Shall be: (1) Safe and (2) Clean.During an observation on 12/4/25 at 12:23 PM, inside a Long-Term Care Dining Room the following was observed, 1.) the ice/water dispensing machine had an accumulation of mold, hard water, scale build-up. 2.) grime and debris were built-up on the coffee machine.Review of the FDA 2017 Food Code Section, 4-202.12 CIP (Clean In Place) Equipment Reflects the following, (A) CIP EQUIPMENT shall meet the characteristics specified under 4-202.11 and shall be designed and constructed so that: (1) Cleaning and SANITIZING solutions circulate throughout a fixed system and contact all interior FOOD-CONTACT SURFACES, and (2) The system is self-draining or capable of being completely drained of cleaning and SANITIZING solutions; and (B) CIP EQIPMENT that is not designed to be disassembled for cleaning shall be designed with inspection access points to ensure that all interior FOOD-CONTACT SURFACES throughout the fixed system are being effectively cleaned. Review of the FDA 2017 Food Code Section, 4-602.11 Equipment Food-Contact Surfaces and Utensils Reflects the Following, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: (5) At any time during the operation when contamination may have occurred. (E) Except when dry cleaning methods are used as specified under 4-603.11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not POTENTAILLY HAZARDOUS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be cleaned: (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil tanks and distribution lines, Beverage and syrup dispensing lines or tubes, coffee bean grinders and water vending equipment: (b) Absent of manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.During an interview on 12/4/25 at12:44PM, NHA revealed she had requested to have the ice/water dispenser and the coffee machine in the dining room cleaned around the end of October. The amount of build-up observed on the equipment reflected they had not been cleaned in some time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to provide safe transfers for 2 residents (R17 and R36) and failed to implement meaningful interventions and increase supervision to prevent falls for 1 resident (R8) of 4 residents reviewed for accidents and falls. Findings include:R36 Review of R36's face sheet with a printed date of 12/4/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: chronic low back pain, stroke, dementia, and numbness and tingling of the left leg. On 12/3/25 at 10:00 AM, R36 was observed being pushed in the hallway in her wheelchair without footrests in place. R36 appeared uncomfortable attempting to hold her feet a few inches off the floor when being pushed in her wheelchair by Certified Nurse Aide (CNA) C. The Surveyor asked CNA C if she should be pushing residents without footrests on their wheelchair and she replied no. The Surveyor asked CNA C, what are you supposed to do when you need to push a resident in a wheelchair that does not have footrests? CNA C said, I guess I need to go find some. R36 responded they are on the shelf in my room. CNA C went to R36's room and returned with footrests. A review of the article Guidelines for Pushing Wheelchairs, dated 3/28/23, revealed, When pushing a wheelchair, safety should always be the top priority. Here are some safety guidelines to keep in mind: Always lock the wheelchair brakes before helping the user in or out of the chair. Use a firm grip on the wheelchair handles and keep your back straight and shoulders relaxed. Be aware of your surroundings and avoid obstacles and uneven surfaces. Always use the footrests when the user is sitting in the chair, and make sure they are properly adjusted. When going down ramps or inclines, always walk backward and use your body weight to control the wheelchair's speed . (https://alzheimerslab.com/guidelines-for-pushing-wheelchairs) R8 Review of R8's Activities of Daily Living (ADL) care plan dated, 6/1/25 to 6/18/25, revealed R8 required assistance with ADL's related to difficulty with memory and sequencing due to dementia. R8 would refuse to use her knee immobilizer at times and was heard of hearing. At times she will decline ADL assistance entirely. Review of R8's mobility care plan dated 6/1/25 to 6/18/25 revealed R8 required assistance with mobility related to dementia and was noted to self-transfer. She often declines assistance with bed mobility, or repositioning. Review of R8's Activity care plan dated 6/1/25 to 6/18/25 revealed, I have identified moderate need and desire to participate in independent type leisure of my choice to enhance my psycho-social well-being. I am a [AGE] year-old woman here for long-term care placement. Goal. I will participate in independent type in leisure interests of my choice and engage in 1 on 1 visits over the next 90 days. Interventions included: Provide for adaptations needed: I have multiple diagnoses including osteoarthritis, muscle weakness, low back pain, and difficulty in walking. I wear a right knee brace at times. Please provide transportation assistance with requested. (Recreational Therapy). Review of R8's fall care plan dated 6/1/25 to 6/18/25 revealed R8 was at risk for falls and injury (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to impaired balance, impaired safety awareness, impaired gait, dementia and history of falls. The interventions did not reveal any increased supervision during wake times. Review of R8's Event Report from 12/1/24 to 12/3/25 revealed R8 had 11 falls in her room from 12/22/24 to 6/17/25. Review of the follow-Up Action documentation for the fall on 2/1/25 revealed the facility had identified that R8 had a fall Risk Score of 29, indicating she was high risk for falls. She had dementia, poor safety awareness and impulsiveness. Interventions listed after each fall revealed multiple changes to R8's toileting schedule and adjustments to equipment in her room. None of the interventions added indicated that the facility had increased R8's supervision. All falls occurred in R8's room and the majority indicated R8 was using the bathroom at the time or in need of using the bathroom when the falls occurred. During an interview with the Nursing Home Administrator (NHA), Director of Nursing (DON) and Activity Director (AD) H on 12/4/25, R8's falls from 12/1/24 to 6/17/25 were reviewed. They confirmed all the falls had occurred in R8's room and they had not implemented any increased supervision during her awake time. The AD H reviewed R8's activity participation and said she will not attend bingo or other group activities. They confirmed that she was staying in her room most of the time. When asked about the activities for residents with advanced dementia that would be offered in a lower stimulating environment and geared toward residents that are impulsive with short attention span, they said they currently do not offer this type of activity program. They confirmed that R8 had a decline in physical function after her fall on 6/17/25 and no longer attempts to self-transfer and continues to spend most of her time in her room. R17 Review of a Face sheet revealed R17 admitted to the facility on [DATE] with pertinent diagnoses which included generalized weakness, alcohol abuse, and cognitive impairment. Review of R17's current Resident Care Summary, printed 12/4/2025 at 2:11 PM, revealed R17 required assistance with ambulation. In an observation and interview on 12/2/2025 at 10:56 AM in room [ROOM NUMBER], Certified Nursing Assistant (CNA) F entered room [ROOM NUMBER] to assist R17 from his toilet to his wheelchair. Upon exiting the room, CNA F reported she did not use a gait belt when assisting R17 to stand up from the toilet and pivot to his wheelchair. CNA F reported gait belt use is required for all residents who need assistance with ambulation. CNA F reported she did not use a gait belt because R17 was in a good mood at the time. R17 reported staff do not always use a gait belt when assisting him. In an interview on 12/3/2025 at 1:05 PM, CNA G reported R17 required assistance of one staff with the gait belt to stand and pivot to his wheelchair. CNA G reported all residents requiring assistance with ambulation require a gait belt to be used. Review of facility policy/procedure Levels of Assistance for Patient Care, effective 7/21/2024, revealed staff are required to use a gait belt when assisting residents requiring assistance with ambulation.