STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235462	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corewell Health Rehab & Nursing Center-Commons Far	21450 Archwood Circle Farmington Hills, MI 48336

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to implement safety interventions to prevent an avoidable fall for one resident (R803), of one resident reviewed for falls, resulting in a transfer to the emergency room where it was discovered R803 sustained a left tibia (shin bone) fracture, a contusion (bruise) to the left upper extremity, and an abrasion to the right upper extremity. Findings include: On 2/24/26 at 9:00 AM, a review of a nursing progress note dated 11/29/25 at 12:48 AM entered into the record by Nurse 'E' was reviewed and read, Note Text: Writer was called by caregiver (Certified Nurse Aide 'D') that resident fell to the floor. Upon rushing to the room, resident was laying on the floor next to bed with body in curled position leaning towards her right side, bed was in high position with the bed unlocked. The CNA (Certified Nurse Aide) said she rolled the resident towards herself but unfortunately the bed rolled backwards and resident fell forward to the floor. Resident sustained hematoma to the forehead, skin tear left deltoid and right elbow. Complained of pain to the left foot .Resident was transferred to hospital via 911 . On 2/24/26 at 9:10 AM, a review of a facility provided investigation file for a fall sustained by R803 was conducted. The file contained a document titled, (Facility Name) POST FALL ANALYSIS AND INVESTIGATION that read, .WHAT NEW INFORMATION WAS DISCOVERED: Staff rolled the patient towards her, the bed rolled away due to unlocked wheels, that leads {sic} to her fall .IMMEDIATE INTERVENTION WAS PUT IN PLACE: .patient was sent to the hospital .ROOT CAUSE: .Staff rolled the patient towards her, the bed rolled away due to unlocked wheels, that leads {sic} to her fall .CONCLUSIONS & RECOMMENDATIONS: Staff education completed to make sure that the bed wheels are locked before making any transfers or repositioning to prevent a fall . New onset or worsening of acute illness that may affect resident's cognitive or physical abilities: Left tibia fracture acquired .Continued review of the investigation file revealed a signed, written statement from CNA 'D' that read, Around 4:50 pm I was doing care on the resident. I rolled her from the wall into my body. The resident's bed slid and she fell onto her side .There was bruising to the head, arm and leg. A review of a typed document contained in the file read, Investigative Overview .The facility determined the accident was caused by (CNA 'D')'s priority to care for (R803) without locking the wheels of the bed . Further review of the file revealed another typed document that read, Below is the nurse managers {sic} investigative report . (Hospital Name) Hospital Report: Imaging test: .diagnosis: Closed displaced fracture of left tibia .other findings: 3. contusion of left upper extremity 4. abrasion of the right upper extremity .HOSPITAL ASSESSMENT AND PLAN: orthopedic surgery consulted, splint applied to the left leg, pain management, non weightbearing {sic} LLE (Left Lower Extremity) at this time . On 2/24/26 at 2:30 PM, an interview was conducted with the facility's Administrator regarding the investigation file. They were asked about R803's fall and confirmed CNA 'D' did not have the wheels on the bed locked when they repositioned R803 causing the bed to roll away and R803 falling from the bed to the floor.A review of a facility provided policy titled, Resident Safety and Precautions revised 4/2024 was conducted and read, (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 0689 Level of Harm - Actual harm Residents Affected - Few	1. Purpose: To outline resident safety standards and describe resident precautions and the associated interventions .3.1 Resident Safety Standards .3.1.2.1 Bed wheels locked .

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F 0711 Level of Harm - Actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review lab values prior to the administration of D5% 0.45% NS (an intravenous fluid solution that contains .45 grams of sodium chloride (NS) and 5 grams of dextrose (sugar) per 100 milliliters) for one resident (R802), of one resident reviewed for the physician's responsibility to review the resident's total program of care at each visit, resulting in R802 receiving continuous IV fluid containing dextrose for approximately two days after the lab reported a critically high glucose level, which subsequently required an emergency transfer to the hospital for hyperglycemia (elevated blood sugar). Findings include: On 2/25/26 at 8:10 AM, a review of R802's closed clinical record was conducted and revealed R802 admitted to the facility on [DATE] and discharged on 12/10/25. R802's diagnoses included: psychotic disorder with delusions, delirium, Alzheimer's disease, stroke, and mood disorder.A progress note entered into the record by Nurse 'B' on 12/8/25 at 12:25 PM read, Note Text: CNA (Certified Nurse Aide) informed writer that resident wasn't herself during morning part of shift. Writer called on call PA (Physician Assistant) 'A'. New orders to {sic} for lab work for STAT (urgent) CBC (complete blood count lab) .CMP (complete metabolic panel lab) .ALL {sic} blood work .collected and sent to lab awaiting results . A review of R802's labs collected on 12/8/25 at 10:30 AM and reported to the facility on [DATE] at 12:37 PM was conducted and revealed R802's blood sugar level was 732 (normal value 70-99). A follow-up note entered into the record by Nurse 'B' on 12/8/25 at 3:24 PM was reviewed and read, Note Text: Writer reviewed result with PA (PA 'A') while in building. New orders for .45 dextrose (herein referred to as D5% 0.45% NS) at 125ml (milliliter) per hr (hour) x 3 liters . Writer obtained I.V {sic} in left forearm but resident pulled it out. Writer attempted to get new access but was unsuccessful .awaiting new orders .A review of PA 'A's progress note dated 12/8/25 was conducted and read, .DIAGNOSIS, ASSESSMENT AND PLAN .Acute kidney injury .Will plan to give 2L IV fluid continuous . It was noted the progress note did not indicate PA 'A' reviewed the stat labs they ordered earlier in the day or the type of IV fluid to be administered. Continued review of R802's nursing progress notes revealed the following: A progress note entered into the record by Nurse 'B' on 12/8/25 at 4:36 PM that read, Note Text: Update. PA called back with new orders to insert hypodermoclysis (the infusion of fluids into the tissue just under the skin for hydration) .Writer inserted hypodermoclysis to resident's abdomen .A progress note entered into the record by Nurse 'G' on 12/9/25 at 12:33 PM that read, Note Text: .Entered residents {sic} room and explained that a PIV (peripheral IV) need to be replaced .resident tolerated procedure well, Hooked up to IVF as ordered (D5% 0.45% NS as ordered by PA 'A' on 12/8/26) .A progress note entered into the record by Nurse 'H' on 12/9/25 at 2:38 PM that read, Note Text: Writer received order clarification for Dextrose 5% 0.45% Sodium chloride (D5% 0.45% NS) infusing @ 125cc (cubic centimeter)/hr times 2 Liters .A progress note entered into the record by Nurse 'I' on 12/9/25 at 10:30 PM that read, Note Text: .resident has peripheral IV in right forearm .D5.45% sodium chloride (D5% 0.45% NS) @ 125cc x 2L (infusion rate of 125 cubic centimeters per hour for 2 liters, or bags of fluid) .bag 2 of 2 infusing . A progress note entered into the record by Nurse 'C' on 12/10/25 at 12:08 AM that read, Note Text: resident {sic} received resting in bed. IV (D5% 0.45% NS) at 125cc .via right arm peripheral IV resident hard to arouse Blood sugar checked results read Hi {sic} (a value greater than what the glucose meter can detect) .call placed to on call. awaiting return call. A progress note entered into the record by Nurse 'C' on 12/10/25 at 12:21 AM that read, Note Text: writer spoke with (NP 'J') concerning residents abnormal lab (high glucose reading) .new order received: (2) give 12 units of Lispro insulin now, recheck in 2hrs. if {sic} blood (continued on next page)

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F 0711 Level of Harm - Actual harm Residents Affected - Few	sugar is still reading Hi {sic} Give an additional 12 units and recheck in 2 hours. Call back if blood sugar is still reading Hi {sic} after second dose of insulin . A progress note entered into the record by Nurse 'C' on 12/10/25 at 1:29 AM that read, Note Text .Blood sugar reading is Hi {sic} .This has gotten stayed {sic} the same since it started A progress note entered into the record by Nurse 'C' on 12/10/26 at 3:05 AM that read, Note Text: writer rechecked resident's blood sugar and the reading was Hi {sic} 12 units of Lispro insulin given as per order. resident is lethargic and difficult to arouse .A progress note entered into the record by Nurse 'C' on 12/10/25 at 3:50 AM that read, Note Text: (Ambulance) called for transportation to (Hospital Name) . On 2/25/26 at 10:55 AM, a review of R802's hospital records was conducted and read the following, .CHIEF COMPLAINT: HIGH BLOOD SUGAR and ALTERED MENTAL STATUS .HISTORY OF PRESENT ILLNESS: .Per EMS .They report the patient on their arrival was receiving D5 fluid hydration .Patient presents with HIGH BLOOD SUGAR Per EMS pt. was found to be hyperglycemic (high blood sugar) at (Facility Name) and staff administered D5 infusion, unk (unknown) amount of insulin given by nurse POC (Point of Care glucose reading from glucose monitor) 300's (glucose levels) . On 2/25/26 at 11:00 AM, an interview was conducted with Physician Assistant (PA) 'A'. They were asked if they were aware R802's blood glucose level was 732 prior to them ordering D5% 0.45% NS for intravenous infusion. They said they were not aware of the elevated glucose level and if they were, they would not have ordered an IV fluid with dextrose. They were then asked if they, themselves reviewed the labs on 12/8/25 prior to ordering the IV fluid. PA 'A' reviewed their progress note for their visit to R802 on 12/8/25 and said they did not document they reviewed the labs. They were then made aware R802 received a continuous infusion of D5% 0.45% NS from 12/8/25 to 12/10/25 and they subsequently were transferred to the emergency room for hyperglycemia. PA 'A' was then asked what should have happened and said they should have reviewed the labs prior to ordering the IV fluids. On 2/25/26 at approximately 11:30 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding the concern. They indicated PA 'A's order for D5% 0.45% NS could have been questioned by the nurse who received the critically high glucose level and implemented PA 'A's order for D5% 0.45% NS. A review of a facility provided policy titled, Role and Responsibilities of Attending Physicians and Advanced Practice Providers-Continuing Care (Rehab and Nursing Centers) effective 4/2024 was conducted and read, .During a physician or advanced practice provider visits, each resident/patient's overall condition will be determined, including: Status of specific medical issues or diagnoses through proper assessment, review of patient information, and conversations with clinical team members .Review laboratory and other diagnostic test with provider visit .Abnormal test results will be analyzed, and a medical rationale will be documented, in addition to rationale for subsequent interventions or decisions not to intervene based on results .