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	04/21/2026

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. This citation pertains to intake 2792320.Based on observation, interview and record review, the facility failed to provide a safe, clean, homelike environment for two (R905 and R907) of three residents reviewed for environment. Findings include:Review of a complaint submitted to the State Agency included concerns that the facility was not clean and when they visited the resident, their bedside and overbed tables were frequently dirty with sticky substances.On 4/20/26 at 10:40 AM, R905 was observed lying in bed, leaning slightly on their left side with a green wedge pillow under their left torso. The left side of the bed ran along the wall/window and the other side had an overbed tray table with the call light on the floor, under the feet of the overbed tray table. The entire edging around the overbed tray table was observed to have lifted/peeled edges which exposed the particle board (non-cleanable surface) and the metal portion of the tray table stand was covered with dried dark substance.The top surface of the bedside dresser was observed to be soiled with a thick white substance.There was a blue floor mat folded up and stored vertically against the dresser/television cabinets that was covered in thick unidentifiable dried debris and stains.The low air loss unit secured to the end of the footboard was set to off power.During this time, R905 was observed moaning and stated Ow when trying to reposition themselves in the bed. They kept their eyes closed and did not respond when spoken to.R907 was observed lying in bed with their bed sheets pulled up to their chin. The surrounding carpet on the left side of their bed was observed with crushed food debris and a red, thick substance was observed on the overbed tray table.On 4/20/26 at 10:45 AM, an interview was conducted with R905's Nurse (Nurse ?I'). When asked about the resident's LAL (low air loss-used to aid in the prevention of skin breakdown) mattress being set to Off, Nurse ?I' confirmed the same and reported that was probably from the old mattress and further reported they had seen maintenance staff in the room recently. When asked if they were aware of any concerns with equipment not functioning, they reported they were not. Nurse ?I' then proceeded to ask this surveyor if the mattress that was currently in place was a LAL mattress.When here recently but when asked if that was part of their plan of care, Nurse ?I? reported No.When asked about the call light on the floor, Nurse ?I? confirmed and went to pick it up and stated R905 moved around a lot and they were just in here and it was within reach. There was no clip and when attempted to put it back next to the resident, the call light kept slipping away. When asked if a clip might help, Nurse ?I? reported it might but confirmed there was none currently in place.When asked about the condition of the floor mat, Nurse ?I' confirmed the various unknown substances and stains. When asked what the process was if staff identified concerns with the resident's room environment such as equipment not working or needing housekeeping services, Nurse ?I? reported staff could put a work order in for maintenance or housekeeping by calling the front desk and putting a work order in. When asked if they had done that recently, they reported No.On 4/20/26 at 12:58 PM, an interview was conducted with the Director of Nursing (DON). When informed of the concerns observed with Nurse ?I' regarding R905's environmental concerns, the DON reported they would have to follow-up but they had a process to initiate work orders. The DON was requested to provide the work order log for the past 30 days.Review of the documentation provided by the Maintenance Staff included all work orders from (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/21/26 - 4/19/26. Review of this documentation revealed there were none documented for the room occupied by R905 and R907.On 4/21/26 at 11:00 AM, an interview was conducted with the Environmental Services (EVS) team which included the EVS Manager (Staff ?O'), Lead Housekeeper (Staff ?P'), and Lead Housekeeper (Staff ?Q').When asked about what services were provided for housekeeping, Staff ?O' reported bathrooms, vacuuming, dusting, but if the resident was in the immediate area, dusting would not be done.When asked if the daily cleaning included the overbed tray tables, bedside dressers and floor mats used, Staff ?O' reported they would do all of that except for the floor mats and reported that was up to the nursing staff to clean.When asked if their staff observed any concerns during their rounds that would require maintenance (such as a peeling overbed tray table), Staff ?P' reported their staff would contact the front desk to put a work order in.On 4/21/26 at 11:15 AM, observation of the room occupied by R905 and R907 was made with Staff ?O', Staff ?P' and Staff ?Q'. The floor mat for R905 was observed with dark brown stains, the carpet surrounding R907's bed remained with food debris (present since 4/20/26). R907's overbed tray table remained soiled with thick, dark red substance. R905's bedside dresser continued to be soiled with a white substance.When informed that these concerns were observed since 4/20/26, Staff ?O' reported they were handling some staffing challenges and there was one housekeeper today for the third floor.According to the facility's policy titled, Environmental Services Cleaning and Quality dated 3/7/2024: .All used patient rooms.will be cleaned a minimum of one time per day. The cleaning should include but is not limited to; the floors, horizontal surfaces, visible soiling, and disinfection of high touch surfaces.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2792320Based on interview and record review, the facility failed to ensure a referral for home health care was made and confirmed before discharge for one resident (R901) of two residents reviewed for discharge planning. Findings include:On 4/20/26 a concern submitted to the State Agency was reviewed which alleged R901 did not have a home health referral made and confirmed by the facility prior to their discharge back into the community on 1/23/26 and that a family member had to call back to the facility a few days later to have them make and confirm the referral resulting a delay in starting home health care. On 4/20/26 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE] and had diagnoses including Type two diabetes and Presence of cardiac pacemaker. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 12/27/25 revealed R901 needed assistance from staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was 15 indicating intact cognition.A review of R901's plan of care revealed the following: Focus-I wish to return home with HHC (Home Health Care) supports. Created on: 12/30/2025 .Interventions-Make arrangements with required community resources to support independence post-discharge (specify: homes care, PT (Physical Therapy), OT (Occupational Therapy), MD (Medical Director), Wound Nurse) Revision on: 02/06/2026 .A post discharge plan of care was reviewed and revealed the following: discharge date [DATE] .In home care or services: [Name of local home health agency] .Starting Date: 1/24/26 .On 4/20/26 at approximately 1:23 p.m., Care Coordinator R (CC R) was queried if they had made the referral to R901's home health agency prior to discharge and they indicated they had not and that a Social Worker that no longer worked for the facility had allegedly made the referral. CC R was queried if they were aware of the concern that R901's home health agency did not receive the referral prior to R901 discharging on 1/23/26 and they reported they were and that they called the Home Health agency the next week and they indicated they had never received the referral. CCR was queried regarding the process for referring and confirmed home healthcare services are linked and they indicated they make the referral via fax, email or phone and they wait for confirmation to ensure the agencies had received the referral and could accept the resident. On 4/20/26 at approximately 2:04 p.m., R901's Home Health Agency was called, and Home Health representative S (HHR S) was queried when they received the referral for R901 to be provided Home Health Care and they reported they had received the medical referral for services via fax on 1/27/26 and services were started on 1/28/26.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2792320.Based on observation, interview and record review, the facility failed to follow nursing professional standards of practice related to physician orders for medication administration for two (R901 and R905) of three residents reviewed for professional standards. Findings include:R901 On 4/20/26 a concern submitted to the State Agency was reviewed that alleged R901 was not properly administered their medications. On 4/20/26 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE] and had diagnoses including Type two diabetes and Presence of cardiac pacemaker. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 12/27/25 revealed R901 needed assistance from staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was 15 indicating intact cognition. A Physician's order revealed the following: Midodrine HCl Oral Tablet 10 MG (Milligrams) (used to treat low blood pressure) Give 1 tablet by mouth three times a day for hypotension HOLD SBP (systolic blood pressure) <110 -Start Date- 12/30/2025 2200 -D/C (discontinue) Date- 01/09/2026 1602 A second Physician's order revealed the following: Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth every 8 hours as needed for Hypotension HOLD BP greater than 110 -Start Date- 01/09/2026 1500 -D/C Date- 01/24/2026 1812 A review of R901's January 2026 Medication Administration Record (MAR) revealed R901 had SBP of less than 110 and was administered the midodrine outside of the parameters on 1/2/26 (101/56-1400 dose), 1/6/26 (101/55-0600 dose), 1/6/26 (93/60-1400 dose), 1/9/26 (106/69-1400 dose). Further review of R901's January MAR revealed R901 was administered the midodrine when their SBP was greater than 110 on 1/1/26-118/48 (0600 dose) and 127/89 (2200 dose), 1/2/26-125/59 (0600) 165/78 (2200 dose), 1/3/26-143/84 (0600) 136/88 (1400) 126/79 (2200), 1/4/26-115/66 (0600) 122/66 (1400), 1/5/26-128/76 (0600) 115/62 (1400) 136/73 (2200), 1/6/26-151/74 (2200), 1/7/26-123/71 (2200), 1/8/26-137/59 (2200). On 4/21/26 at approximately 8:48 a.m., Nurse Manager G (NM G) was queried regarding the parameters that were transcribed into R901's midodrine order and they indicated they were the incorrect parameters because midodrine is supposed to be administered when the blood pressure is low not held when it is low. NM G was queried if the parameters were transcribed wrong and if they should have been to hold the midodrine if the SBP was over 110. R901's January MAR was reviewed with NM G that indicated the midodrine was administered outside of the parameters in the order and they reported that the Nursing staff should have clarified the order with the Physician regarding the parameters and corrected the order to reflect the appropriate parameters for administration. On 4/21/26 at approximately 10:42 a.m., A review of R901's midodrine order was reviewed with the Director of Nursing and indicated that the parameters in the scheduled midodrine order were incorrect and should have been clarified with the Physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R905's active physician orders and corresponding Medication & Treatment Administration Records (MAR/TAR) included: An order started on 2/27/26 for bilateral heel protectors at all times when in bed every shift for heel protection. The MAR was documented as completed via a check mark and nurse initials from 4/1/26-4/20/26 with no documentation of any charting exceptions (such as refusals by resident, missing, etc.). Nurse 'I' had documented the MAR entry with a check mark as completed for today. An order started on 11/21/25 for Skilled care boots while in bed, off while out of bed every shift for Heel Pressure reduction – Start Date- 11/21/2025 2300. The TAR was documented as completed via a check mark and nurse initials from 4/1-4/20/26 (except one blank entry on 4/3/26 day shift) with no documentation of any charting exceptions. Nurse 'I' had document An order started on 10/15/25 for Low air loss mattress (LAL). On 4/20/26 at 10:40 AM, R905 was observed lying in bed slightly on their left side with a green wedge pillow under their left side. There was no hearing aids observed in use at this time. During this time, R905 was observed moaning and stated Ow when trying to reposition themselves in bed (restless). They kept their eyes closed and did not respond when spoken to. The low air loss unit secured to the end of the footboard was set to off power. There was a blue soft boot that had a label for heel drop stored in between the two closet units. R905 was not observed to have any heel protectors in place (feet were bare). On 4/20/26 at 10:45 AM, an interview was conducted with the resident's Nurse (Nurse 'I'). When asked if the resident had any current skin concerns, Nurse 'I' reported they did not. When asked about R905's LAL mattress unit at the end of the bed, Nurse 'I' confirmed it was off and reported that was probably from the old mattress and further reported they had seen maintenance in the room recently. When asked if they were aware there was an active order to have that in place as part of their plan of care, Nurse 'I' reported No. When asked about the resident's moaning, Nurse 'I' reported the physician was making rounds today and intended to see her about increase in pain. Nurse 'I' reported the resident recently signed onto hospice and moved around a lot in bed. When asked about if the resident utilized any soft boots or heel protectors, Nurse 'I' reported they did not. When asked about the soft boot observed between the two closets, Nurse 'I' reported that was one of the boots for R905. When asked if there was another boot, Nurse 'I' proceeded to open R905's closet and removed and placed together with the other boot. When asked to clarify if R905 should have boots or some sort of heel protectors in place, Nurse 'I' reported No. At that time, Nurse 'I' was asked to review the resident's active physician orders and compare to the documentation on the MAR and TAR. When asked about the entries of check marks and visual cue of green which indicated the above orders for the skilled care boots, bilateral heel protectors and LAL mattress were verified as completed, Nurse 'I' confirmed they had marked that as completed this morning. When asked why they had marked it as completed if they had not actually completed it, Nurse 'I' offered no further explanation. Further review of the clinical record revealed R905 was initially admitted into the facility on 4/4/18, readmitted on [DATE] and recently signed onto hospice on 3/30/26. Diagnoses included: Alzheimer's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease with late onset, contusion of unspecified part of head, unspecified fracture of shaft of unspecified fibula, displaced intertrochanteric fracture of right femur, unspecified glaucoma, unspecified convulsions, dementia in other diseases, manic episode, major depressive disorder, and fracture of unspecified part of neck of left femur. According to the Minimum Data Set (MDS) assessment dated [DATE], R905 had severe cognitive impairment and was dependent upon staff for most aspects of care. A significant change MDS assessment was currently in progress. On 4/20/26 at 12:58 PM, an interview was conducted with the Director of Nursing (DON). When informed of the observation and interview with Nurse 'I' regarding R905's lack of soft boots, heel protectors, and LAL mattress, the DON reported they would need to follow up. When asked what their process was for documenting on the MAR and TAR and the DON reported the nurse should process for completion and document once completed. According to the facility's policy titled, Clinical Nurse LTC (Long Term Care) dated 12/2023: .All employees in all positions must.Ensure that services are provide in accordance with state and federal regulations, accreditation and compliance requirements.The clinical nurse, under the ANA scope of practice utilizes the framework of the nursing process to provide not only professional but exceptional nursing care by incorporating.code of ethics and other policies.ESSENTIAL FUNCTIONS.Implements the plan and then continuously re-evaluates the patient/resident status and nursing care to make any necessary modifications to provide the most effective plan of care.Communicates documentation in the patient/resident record in a timely, accurate and concise manner.Administers and documents medication in accordance with established standards, making certain that the Medication Administration Record (MAR) is complete.Documents in the patient/resident record as appropriate including nursing interventions, nursing notes and all other pertinent problems patient/resident may be experiencing.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2792320.Based on observation, interview and record review the facility failed to provide proper assistive devices to maintain hearing for one (R905) of two residents reviewed for assistive devices. Findings include:Review of a complaint reported to the State Agency included concerns that read, I brought her hearing aids to the facility so that she could hear. Staff wouldn't give them to her and wouldn't give her time to get them prior to going to PT (Physical Therapy), so she couldn't hear while in therapy.Review of R905's physician orders and corresponding Medication/Treatment Administration Records (MAR/TAR) included: Apply resident hearing aids upon awaking daily for better communication. every day shift for communication - Start Date - 01/22/2026 0700. The MAR was documented as completed via a check mark and nurse initials from 4/1-4/20/26 with no documentation of any chart codes/follow up codes such as missing, refused, etc. The documentation revealed Nurse ?I' had documented this was completed for 4/20/26 at 7:00 AM. Remove resident hearing aids prior to bedtime and lock up in nursing cart. every evening shift for communication - Start Date - 01/22/2026 1500. The MAR was documented as completed via a check mark and nurse initials from 4/1-4/19/26 with no documentation of any chart codes/follow up codes to indicate concerns such as whether they were missing, refused, etc.On 4/20/26 at 10:40 AM, R905 was observed lying in bed slightly on their left side with a green wedge pillow under their left side. There were no hearing aids observed in use at this time. During this time, R905 was observed moaning and stated Ow when trying to reposition themselves in bed (restless). They kept their eyes closed and did not respond when spoken to.On 4/20/26 at 10:45 AM, an interview was conducted with Nurse ?I'. When asked about the resident's use of hearing aids, Nurse ?I' reported they should be in the charger at the desk. When asked why they were not applied since the order was to be completed upon awaking daily for better communication at 7:00 AM, Nurse ?I' went back to check R905 and confirmed the resident was not wearing any hearing aids. When asked who was responsible to ensure this was done, Nurse ?I' reported that was the Nurse's responsibility.At that time, Nurse ?I' was asked to review R905's current physician orders and compare to what was documented on the Medication Administration Records (MARs). When asked about their entry on 4/20/26 at 7:00 AM that this was completed via a check marks and visual cue of green color, Nurse ?I' which indicated the medication/order had been completed for the provision of the boots, the hearing aids and LAL mattress, Nurse ?I' confirmed they had marked that as completed. When asked why they had marked it as completed if they had not actually completed it, Nurse ?I' reported they had all shift to put the hearing aids in. When asked to confirm the order, Nurse ?I' confirmed it was ordered to be done upon awaking and was scheduled with a time for 7:00 AM.When asked to observe R905's hearing aids in the medication cart as this was indicated on the current orders, Nurse ?I' reported those were not kept in the medication cart, they were kept on the charger at the nursing desk. Nurse ?I' then proceeded to retrieve R905's hearing aids and reported there was only one, the other was missing. When asked when they had last seen both hearing aids, Nurse ?I' reported they were not sure. When asked why their documentation reflected previous entries that had been done when it actually was not in the MAR, Nurse ?I' offered no further response.Review of the clinical record revealed R905 was initially admitted into the facility on 4/4/18, readmitted on [DATE] and recently signed onto hospice on 3/30/26. Diagnoses included: Alzheimer's disease with late onset, unspecified glaucoma, unspecified convulsions, dementia in other diseases, manic episode, and major depressive disorder.According to the Minimum Data Set (MDS) assessment dated [DATE], R905 had severe cognitive impairment , had minimal difficulty with hearing, and was marked (incorrectly) as not using a hearing aid.Review of a communication care plan created on 8/8/22, revised on 11/7/23 documented, I have problems communication <sic> due to I am slightly HOH (hard of hearing). There were no interventions included for the use of hearing aids.On 4/20/2 at 12:58 PM, an interview was conducted with the Director of (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON). When informed of the concerns observed with Nurse ?I' regarding R905's hearing aids, the DON reported those were never kept in the medication cart but at the nursing desk on the charger. When they were informed of the observation the resident was not wearing their hearing aids and the identification that one was now missing, the DON reported they would have to follow-up. When asked how the missing hearing aid was not identified prior to now if the other nurses were documenting they were being implemented and removed, the DON reported they were not able to offer any further explanation.According to the facility's policy titled, Hearing and Vision Services dated 8/8/25: .Purpose To ensure that residents receive proper treatment and assistive devices to maintain.hearing abilities.Assistive devices include, but not limited to.Hearing aides. This policy did not address the staff's process for ensuring placement per plan of care.

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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** This citation pertains to intake 2792320.Based on observation, interview, and record review, the facility failed to implement fall prevention interventions per plan of care for two (R903 and R905) of three residents reviewed for accidents. Findings include:R903 On 4/20/26 at approximately 9:28 a.m., 12:07 p.m., 1:13 p.m. and 2:49 p.m., R903 was observed in their room, laying in their bed. R903's bed was observed to be high (approximately 3.5 ft off the floor) without any floor mats around the bed. A floor mat was observed on its side, laying up against the wall at the foot of the bed. On 4/20/26 the medical record for R903 was reviewed and revealed the following: R903 was initially admitted to the facility on [DATE] and had diagnoses including Alzheimer's and Hearing loss. A review of R903's MDS (minimum data set) with an ARD (assessment reference date) of 2/27/26 revealed R903 needed assistance from facility staff with most of their activities of daily living. R903's BIMS score (brief interview of mental status) was six indicating severely impaired cognition. A review of R903's plan of care revealed the following: Focus-I am at risk for falls Dementia, Gait/mobility impairments, Incontinence, Osteopenia, Weakness fall 8/17/25 Readmit 12/29/25 Created on: 05/22/2024 Revision on: 12/30/2025.Interventions-Bed in lowest position Revision on: 10/03/2024 Do not leave alone in room in wheelchair Dycem Gripper to w/c cushion on top and bottom Revision on: 05/28/2024 Mats on floor non-slip footwear at all times . On 4/20/26 at approximately 2:50 p.m., R903's room was observed with Nurse I and they were shown R903's bed up high and the floor mat against the wall. Nurse I indicated they would have to lower R903's bed to a low bed status (to reduce the potential from injury of a fall) and to place the floor mat on the floor on the side of R903's bed. Nurse I was queried if R903 was a fall risk and they indicated they were and they would have to adjust R903's position in the bed. On 4/21/26 at approximately 8:48 a.m., Nurse Manger G was queried regarding the multiple observations of R903's fall interventions not being implemented and they reported that they should be. R905 On 4/20/26 at 10:40 AM, R905 was observed lying in bed slightly on their left side with a green wedge pillow under their left side. The bed was in an elevated position (not low to the floor). There was an overbed tray table placed to the right side of the bed and the call light was on the floor, out of reach and under the feet of the overbed tray table. There was a soiled blue mat folded and resting against the closet. There was a regular mattress (non-perimeter) in place. On 4/20/26 at 10:45 AM, an interview was conducted with the resident's Nurse (Nurse 'I'). When asked if the resident was considered a fall risk, Nurse 'I' reported they were not. When asked about the folded floor mat, Nurse 'I' didn't respond and proceeded to unfold and place next to the bed. When asked if that should be utilized when the resident was in bed, Nurse 'I' reported It should. Nurse 'I' further reported the staff probably just forgot to put the mat back in place after they assisted with breakfast this morning. When asked about whether the resident should have a perimeter mattress in place, Nurse 'I' reported they were not aware of that. (continued on next page)

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	04/21/2026

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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the documentation provided by the facility via the facility matrix identified R905 had a fall with injury. Review of the clinical record revealed R905 was initially admitted into the facility on 4/4/18, readmitted on [DATE] and recently signed onto hospice on 3/30/26. Diagnoses included: Alzheimer's disease with late onset, contusion of unspecified part of head (11/28/25), unspecified fracture of shaft of unspecified fibula, displaced intertrochanteric fracture of right femur (11/28/25), unspecified glaucoma, unspecified convulsions, dementia in other diseases, manic episode, major depressive disorder, and fracture of unspecified part of neck of left femur (4/4/18). According to the Minimum Data Set (MDS) assessment dated [DATE], R905 had severe cognitive impairment and was dependent upon staff for most aspects of care and had no falls since the prior assessment. A significant change MDS assessment was currently in progress. Review of R905's care plans included one for fall risk which was created on 4/4/18 and revised on 11/29/25 which read: I am at risk for falls/injury r/t (related to) decreased mobility, HTN (Hypertension), OA (Osteoarthritis), COPD (Chronic Obstructive Pulmonary Disease), anxiety, dementia, hx (history) of left hip Fracture, Incontinence, high risk medication use. I use sit to stand for transfers. I have my bed against the wall and mat next to bed for safety. I at times sit on the edge of my bed. I tend to reach for my phone and other items on my night stand so I need it to be close to me while I am in the bed. I have a history of placing myself on the floor and taking my clothes off, I will become agitated and frustrated due to my disease process – I don't understand why I am so confused. 11/28/25 Fall with Hematoma and multiple injuries. Interventions included: Added 11/19/18, place resident phone/personal items within reach. Added 5/10/28, Perimeter mattress. Added 7/25/21, I will notify the staff and use my call light when I need to go to bed. Added 5/19/21, bed in low position. Added 5/19/21, Mats on floor. No date of when added, I am on the falling star program. Review of the progress notes included an entry on 11/29/25 at 12:49 AM that read: Writer was called by caregiver that resident fell to the floor. Upon rushing to the room, resident was lying 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 Nursing Assistant) 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. (continued on next page)

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	235462	A. Building B. Wing	04/21/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R905 returned to the facility with diagnoses that included: contusion of unspecified part of head, and unspecified fracture of shaft of unspecified fibula. (Although this fall with major injuries occurred prior to the recertification survey conducted 12/18/26, as well as an abbreviated survey on 2/25/26 in which accidents was cited, concerns were identified with observations of lack of implemented fall prevention interventions during the current abbreviated survey.) On 4/20/26 at 12:58 PM, an interview was conducted with the Director of Nursing (DON). When informed of the observation and interview with Nurse 'I' regarding R905's lack of fall prevention interventions, and lack of awareness of R905 being at risk for falls, the DON reported the nursing staff should be aware and interventions should be in place. When asked about the lack of perimeter mattress, the DON reported they would have to follow-up. According to the facility's policy titled, Fall Prevention Program dated 12/18/23: .To prevent falls of residents at risk and to communicate resident-specific interventions to staff.The Care Plan will include individualized interventions for fall prevention.

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	235462	A. Building B. Wing	04/21/2026

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure the Director of Nursing (DON) did not serve as the charge nurse for an occupancy over 60 residents. This deficient practice has the potential to affect all 99 residents that reside within the facility. Findings include:On 4/21/26 at 11:45 AM, an interview was conducted with the Staffing Scheduler (Staff ?N'). When asked if there were any staffing challenges over this past weekend as there was a complaint voiced from a resident, Staff ?N' reviewed their documentation and reported on midnights there were usually two nursing assistants per hall and a nurse. They acknowledged there were several nurse and nursing assistant call-ins and further reported the DON and a Nurse Manager ended up being assigned to a medication cart to work as a charge nurse on Sunday (4/19/26). When asked if that was typical, Staff ?N' reported it was not, but reported there were additional times the DON helped out when a charge nurse was needed.On 4/21/26 at 12:25 PM, an interview was conducted with the DON. When asked if they worked as a charge nurse, the DON confirmed they had this past weekend and further reported it didn't happen often, but they would if it was needed. When asked if they were aware of the regulatory requirements, the DON reported they were going to look into that further. The DON was requested to provide documentation such as a job description of which included any limitations, however there was no additional documentation provided by the end of the survey.