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	12/18/2025

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 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. Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include:On 12/16/2025 at 9:20 AM, there were 3 uncovered bins of clean dessert sized cups stored next to the handwashing sink. When queried about the storage of the clean dishware, Certified Dietary Manager (CDM) M stated, they have to have covers on them.According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted.On 12/16/2025 at 10:00 AM, there were 2 plastic wrap covered pans of whole, cooked pork loins on a speed rack located in the food prep area. The pans were dated 12/15. When queried about the pork loins, CDM M stated they had been cooked on 12/15/25 and placed in the cooler to be served for lunch on 12/16/25. The internal temperatures of the whole pork loins ranged from 48-51 degrees Fahrenheit. Review of the facility's cooling log revealed the pork loins had not been placed on the cooling log, to ensure the meat was cooled to 41 degrees Fahrenheit or less in the appropriate timeframe. CDM M stated she was unsure why staff did not utilize the cooling log for the pork loins. According to the 2022 FDA Food Code section 3-501.14 Cooling, (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2675245. Based on interview and record review, the facility failed to ensure the physician was notified when a blood pressure medication was not available for four days for one (R121) of one resident reviewed for medication availability. Findings include: On 12/16/25 at 10:45 AM, an interview was conducted with R121 regarding her care in the facility. R121 reported her main concern was when she was admitted into the facility on [DATE], a prescribed medication used to treat high blood pressure was not available and she did not receive it until 12/15/25. R121 reported the nurse told her the medication had to be ordered from the pharmacy, but then there was no follow up after that. A review of an After Visit Summary from the hospital for R121 revealed they were prescribed candesartan-hydrochlorothiazide (a medication used to treat high blood pressure) 32-12.5 milligrams (mg) daily. A review of the facility's Physician's Orders revealed an order for candesartan cilexetil-HCTZ (hydrochlorothiazide) 32-12.5mg daily. A review of R121's Medication Administration Record (MAR) for December 2025 revealed R121 did not received the blood pressure medication on 12/11/25, 12/12/25, 12/13/25, and 12/14/25. A review of R121's progress notes revealed the following: An eMAR (electronic Medication Administration Record) note dated 12/11/25 that noted, Med (medication) not available on cart or (backup medication dispensing machine). A review of a History and Physical progress note written by the Attending Physician on 12/11/25 revealed no documentation of the candesartan cilaxetil-HCTZ not being available. The physician documented to continue with the current treatment for blood pressure. A review of an eMAR progress note dated 12/12/25 noted candesartan cilaxetil-HCTZ was on order. A review of a Provider Progress Note dated 12/12/25 revealed the following documentation, HTN (hypertension): Blood pressure controlled on current Rx (prescription). Continue to monitor blood pressure. It was not documented in the note that the medication was not available for administration to R121. A review of an eMAR note dated 12/13/25 revealed, not available will follow up with pharmacy. A review of an eMAR note dated 12/14/25 revealed, Pharmacy contacted - spoke to (name) states she is not sure why it was not cycling out, but she will send it out today. There was no documentation that indicated a medical provider was notified that the medication was not available or that anyone spoke with the pharmacy prior to 12/14/25. On 12/17/25 at 12:22 PM, an interview was conducted with the Director of Nursing (DON). When queried about the facility's protocol when a prescribed medication was not available for administration, the DON reported the nurse would check in the backup medication dispenser. If the medication is not available in back up, the pharmacy was contacted. The medical provider was usually contacted to see if there were any further instructions, alternative medication to give, or if the delay in administration was okay. The DON reported she was unaware R121 did not receive the blood pressure medication for four days. On 12/18/25 at approximately 1:30 PM, the DON followed up and reported the medication was not available at the pharmacy and therefore it was delayed. However, the pharmacy technician did not communicate with the facility. The DON acknowledged there should have been follow up with the physician. A review of R121's clinical record revealed R121 was admitted into the facility on [DATE] with diagnoses that included: HTN.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate positioning and range of motion (restorative therapy services) for two (R71, R97) of three residents reviewed for positioning and range of motion. Findings include: R97 On 12/16/25 at 12:40 p.m., R97 was observed in their room in their hospital bed, wearing a hospital gown. R97 had soft positioning boots on their feet, which placed their feet into dorsiflexion (toes pointed up towards the ceiling). On 12/16/25 at 12:42 p.m., R97 reported they wanted to receive more range of motion exercises, however, said restorative therapy was only about once a week. R97 explained they wanted to receive more range of motion, especially for their feet, which felt tight. R97 stated sometimes staff had difficulty applying their positioning boots because their foot muscles were tight, which caused them discomfort. R97 said they wondered if range of motion exercises for their feet would help. Review of the Minimum Data Set (MDS) assessment, dated 9/16/25, revealed R97 was admitted to the facility on [DATE], with diagnoses including dementia, multiple sclerosis, and depression. The assessment showed R97 required supervision or touching assistance with eating and was dependent for transfers. The range of motion assessment revealed R97 had range of motion impairment on one upper extremity and both lower extremities. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 10/15, which showed R97 had moderate cognitive impairment. Review of R97's most current restorative program, requested and received from the Director of Rehab (DOR), Physical Therapist E, on 12/18/25, revealed the program was dated on 6/24/25, and showed R97 was scheduled to receive restorative therapy two to three times a week for six weeks (through 8/05/25). The program included active assistive range of motion and strengthening exercises for their arms and legs, bed mobility exercises, balloon toss exercises, and hand grip exercises. The goal was to maintain their current level of function and ability to assist with activities of daily living. On 12/17/25 at 1:38 p.m., Certified Nurse Aide (CNA) K was asked about R97's participation in the restorative therapy program, since R97 said they were in restorative therapy. CNA K reported they worked in the restorative therapy program 2-3 times a week, however said they could not recall if R97 was in the program or not. When asked about any missed restorative visits, as reported by R97, CNA K explained they were sometime pulled to the floor to work as a nursing aide, and then the residents missed their restorative therapy, which was not always able to be rescheduled. CNA K reported they worked in the program on their own as a restorative aide, along with another restorative aide. CNA K said they would let the Unit Manager, Registered Nurse (RN) L, know when a resident needed to be discontinued from the program. CNA K reported they documented their visits in the facility progress notes in the Electronic Medical Record (EMR), and they documented in the progress note when a resident was discontinued from restorative therapy. Review of R97's restorative nursing progress notes in the Electronic Medical Record (EMR) with CNA K revealed R97's last restorative progress note was dated 11/14/25. Further review of R97's restorative nursing progress notes revealed there was no documentation showing a discussion with R97 regarding their restorative therapy was ending, including on 11/14/25, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the last date of service. There was also no documentation of any skilled oversight by nursing or therapy from 7/04/25 through 11/14/25. Additionally, the note showed R97's restorative program was completed, with an additional six weeks added. This showed the restorative program continued beyond the 12-week duration specified. On 12/17/25 at approximately 5:15 p.m., the Unit Manager, RN L, was asked about R97's restorative program, and any oversight provided. Review of R97's EMR with RN L showed R97's physician orders remained active, beginning 6/24/25, and had not been discontinued. Further review of R97's EMR with RN L revealed the current task section showed current restorative exercises for R97 in the active tasks. On 12/17/25 at approximately 5:25 p.m., RN L clarified R97 was not receiving restorative therapy services and acknowledged the orders and tasks should have been discontinued. RN L was made aware R97 believed they were still receiving restorative services and they reported currently receiving restorative therapy about once a week. RN L reported they planned to follow-up and ensure restorative orders and tasks were discharged once a resident's restorative program was completed. RN L confirmed they oversaw the restorative program and typically discharged a resident's restorative orders upon communication from the restorative aides. RN L stated they were uncertain what occurred, with the orders and tasks being in place, and R97 believing they remained in the restorative program. RN L conveyed they understood the concerns and the importance of restorative program oversight for optimal communication with restorative aides and residents. RN L said they had reclarified the documentation expectations with the restorative aides upon learning of the concern and would address concerns with any missed visits. Review of the policy, provided on 12/19/25, revealed, .Restorative Services, revised 1/2025, Purpose: Improving and maintaining the functional skills and physical conditions of the resident through assessment and implementation of restorative services to restore or maintain the resident's highest level of functioning. Procedure: 1. Rehabilitative Services (OT/PT, etc.) will conduct a screening for restorative needs. 2. A referral will be given to nursing with a recommended restorative plan. 3. Nursing will obtain the order from the provider and implement a care plan. 4. Nursing will give notice to the responsible party. 5. Restorative Services initiate restorative plan with the resident. 6. Documentation of residents' progress weekly and as needed. 7. Assessments for change of function will be quarterly or as needed to change, update or discontinue restorative plan. R71 On 12/16/25 at 10:07 AM, R71 was observed sitting in a wheelchair in the Nutrition/Dayroom. R71 was leaning forward, with a rounded back, and her forehead was pressed against the edge of the table. Facility staff was observed placing a bag of large, plastic building blocks on the table in front of R71. R71 was then observed to keep her eyes level with the edge of the table and reach her arms above the level of her head to play with the building blocks. On 12/16/25 at 1:00 PM, R71 was observed sitting in the same spot in the Nutrition/Dayroom, leaning forward in the wheelchair, with her head pressed against the edge of the table. Certified Nursing Assistant [CNA] 'F' was observed to place a tray of food in front of R71, then sit at an adjacent edge of the square table, then proceed to assist R71 with eating by reaching under the corner of the table (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and up to R71's mouth due to R71's head being pressed against the edge of the table. Review of the clinical record revealed R71 was admitted into the facility on 9/9/25 with diagnoses that included: dementia, peripheral vascular disease and chronic obstructive pulmonary disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R71 had severely impaired cognition. Review of R71's Physical Therapy care plan created 9/10/25, revealed interventions that read in part, .WC [wheelchair] mobility/management. Adaptive/assistive device. On 12/17/25 at 9:07 AM, R71 was observed sitting in the Nutrition/Dayroom leaning forward in her wheelchair with her head against the edge of the table. On 12/17/25 at 10:50 AM, R71 was observed sitting in the same spot, it the same position, when she dropped an empty can of cola on the floor. Licensed Practical Nurse [LPN] 'G' asked R71 if she wanted another cola then proceeded to place a can of cola with a straw in it on the table in front of R71. R71 sat up, her back against the wheelchair back, reached for the can of cola and take a drink from the straw. R71's head was observed in a slight forward position, when sitting upright. After taking a drink from the cola, R71 leaned forward in her chair and placed her head at eye level with the table and reached her arms above the level of her head to play with the building blocks on the table. LPN 'G' was asked about R71 sitting with her head against the table. LPN 'G' explained R71 always sat leaning forward. On 12/17/25 at 11:01 AM, the Therapy Director was interviewed and asked if R71 was currently receiving therapy. The Therapy Director explained she had been evaluated by Physical Therapy [PT] and Occupational Therapy [OT] when she was first admitted into the facility but was not currently receiving therapy. The Therapy Director was asked about R71 sitting leaning forward with her pressed against the table. The Therapy Director explained R71 was not demonstrating that behavior when she had been evaluated previously. The Therapy Director was asked how the Therapy Department would know if there was a change in a residents' posture. The Therapy Director explained she would expect the facility staff to bring it to their attention so they could be re-evaluated, since R71 was not due for their quarterly assessment. Review of R71's Physical Therapy Evaluation dated 9/10/25 read in part, .New Goal: Patient will increase dynamic sitting balance to Good and dynamic standing balance to Fair- in order to reduce the risk for falls, facilitate upright posture and decrease LOB [loss of balance] during functional mobility. Sitting Balance: Static Sitting = Fair+ (accepts minimal resistance); Dynamic Sitting = Fair (minimal weight shifting ipsilateral/front, difficulty crossing midline). On 12/17/25 at 1:08 PM, observation of CNA 'F' assisting R71 with her lunch revealed R71 leaning forward with her head against the table and CNA 'F' providing the food under the corner of the table up to R71's mouth. On 12/17/25 at 1:15 PM, CNA 'F' was interviewed and asked about R71's positioning, of sitting with her head against the table. CNA 'F' explained R71 had always sat like that since she had been admitted . CNA 'F' was asked about assisting R71 with eating while leaning forward. CNA 'F' explained they would try to get R71 to sit up, but she always wanted her head down, so that was the only way to assist her with eating. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/25 at 9:40 AM, the Director of Nursing [DON] was interviewed and asked about R71's positioning of sitting leaning forward with her head against the table and having to have her arms above the level of her head to play with the building blocks and not being able to see the other people in the room due to always looking down. The DON explained the Therapy Director had informed her they were going to re-evaluate R71 to see if she needed therapy. The DON was asked who usually informed the Therapy Department if a residents' positioning was declining. The DON explained the nurse would make the referral. On 12/18/25 at approximately 10:00 AM, R71 was observed being pushed in her wheelchair from the Nutrition/Dayroom to her room by a staff member. R71 was observed to be leaning forward in the wheelchair while being pushed. On 12/18/25 at 11:02 AM, R71 was observed sleeping in her bed on her right side. R71 back appeared to be mostly straight with her head a little forward. On 12/18/15 at 11:03 AM, LPN 'H' was interviewed and asked about R71 in her room sleeping. LPN 'H' explained R71 had been leaning forward in her chair and looked tired, so she had someone take her back to her room because she did not want R71 to fall forward out of the wheelchair. LPN 'H' was asked how R71 was usually positioned when sitting. LPN 'H' explained she did not remember R71 leaning that far forward, but if she continued to do so, she would notify the Therapy Department. On 12/18/25 at 11:30 AM, Physical Therapist [PT] 'I' was interviewed and asked about R71 positioning. PT 'I' explained he had evaluated R71 and she had a slight kyphotic posture [excessive forward curve of the spine] but considered R71's leaning forward more of an issue with her core strength [strength of a group of muscles that stabilize and control the pelvis and spine] than structural [curvature of the spine]. When asked about R71 sitting in the wheelchair all day with her head on the table, PT 'I' explained R71 should not be sitting for long periods as her core strength would decrease the longer she was sitting. Review of R71's Physical Therapy Evaluation dated 12/18/25 read in part, .New Goal: will demo [demonstrate] F [forward] balance in sitting without extra leaning in WC [wheelchair] to maintain proper posture for feeding. Reason for Referral: . is referred to rehab due to abnormal posture causing extreme leaning in WC and is at high fall risk, pts [patients] ability to stay in WC is also affected by her poor cognitive function and lack of safety. Therapy Suggested high back [wheelchair] with elevated leg rest with 15-30 degree tilt as needed. Also suggested full lap tray to prevent extreme leaning in WC. Will suggest scheduled seating in WC before dining. Sitting Balance: Static Sitting = Fair- (able to maintain with UE [upper extremity] support); Dynamic Sitting = Poor+ (sits unsupported with Min A [minimal assistance] and reach to ipsilateral side, unable to weight shift). It should be noted this evaluation showed a decline in R71's sitting balance.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure ongoing assessment and monitoring for weight loss for one (R79) of two residents reviewed for nutrition. Findings include:On 12/17/2025 at 7:40 AM, 10:30 AM, and 1:00 PM, R79 was observed lying in bed, asleep and did not awaken when approached. At each of these observations an intravenous pole was stored next to the bed but did not have any fluids hung and/or being administered.12/17/2025 7:48 AM an interview was conducted with the resident's Nurse ?B'. When asked about R79's clinical status, Nurse ?B' reported the resident was currently declining clinically. When asked what that meant, Nurse ?B' further reported they were not eating or drinking, recently received intravenous fluids, and had skin breakdown.Review of the clinical record revealed R79 was initially admitted into the facility on 1/25/22 with diagnoses that included: localized swelling, mass and lump, right lower limb, osteoarthritis, hematemesis, Alzheimer's disease with late onset, malignant neoplasm of colon, and pressure ulcer/injury to right gluteal fold (in-house acquired onset date of 11/26/25) and coccyx (in-house acquired onset date 10/21/25).According to the Minimum Data Set (MDS) assessment dated [DATE], R79 had severe cognitive impairment, was dependent upon staff for all aspects of care, weighed 130 pounds (lb) with no weight loss or gain, received a mechanically altered/therapeutic diet, and had no pressure ulcers but was at risk for developing them.Further review of the electronic health record (EHR) revealed the following significant weight changes for R79. Documentation included:On 10/15/25, the resident weighed 130.6 lbs. The EHR system also flagged -7.5% change [Comparison Weight 7/17/2025, 142.3 Lbs, -8.2%, -11.7 Lbs].On 11/13/25, the resident weighed 120.7 lbs. The EHR system also flagged -5.0% change [Comparison Weight 10/15/2025, 130.6 Lbs, -7.6%, -9.9 Lbs] -7.5% change [Comparison Weight 9/10/2025, 136.4 Lbs, -11.5%, -15.7 Lbs].On 12/9/25, the resident weighed 107.6 lbs. The EHR system also flagged -5.0 change [Comparison Weight 11/13/2025, 120.7 Lbs, -10.9%, -13.1 Lbs] -7.5% change [Comparison Weight 9/10/2025, 136.4 Lbs, -21.1%, -28.8 Lbs].There were no re-weights documented as completed for any of the above weights as of this review.Review of the care plans included a nutritional care plan initiated on 1/27/22, and most recently revised on 8/18/25 which included an intervention revision on 8/18/25 which included four nutritional supplements. This care plan had not been revised since, to address the identified significant weight loss, or address what other interventions were implemented once these weight fluctuations were identified.Review of the progress notes revealed the most recent dietary note from Registered Dietitian (RD 'C') was from 4/28/25 which identified a significant weight loss at that time. The note further identified, .RD will cont. (continue) to monitor and F/U (Follow-Up) w/ (with) IDT (Interdisciplinary Team).Review of the most recent nutritional assessment was completed on 10/15/25 by RD ?C?. There was no documentation of an RD evaluation and/or monitoring available for review in the EHR since 10/15/25. This assessment documented, in part: .Current Weight 130 .Usual Body Weight 135-145 .Stable .Other: L. (Left) gluteus PI (Pressure Injury).per skin & wound note on 10/14 .She continues to be confused, unable to answer questions with reliability. Continues with fair-good appetite with documented intakes averaging ~50-75%. Noted wt. (weight) variance x30d. requested rewt. (re-weight) She continues to be well accepting of (four nutritional supplements).MNA (Mini Nutritional Assessment) score-10 indicating at risk for malnutrition. Recommend continue with poc (plan of care); continues with good intake of meals/supplements. Continue to monitor . There was no further follow-up documented by a RD following this assessment, nor were there any documentation included they had been informed of the changes in the resident's oral intake, decline and issues in obtaining re-weights.Review of the interdisciplinary progress notes included:On 12/11/25 at 10:49 PM, a change of condition assessment by Nurse ?A' read: .Situation.Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts) Functional decline (worsening function and/or mobility) Skin wound or (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ulcer.Weight.107.6 lb - 12/9/2025.New or Change in Medications IV or subcutaneous fluids.On 12/9/25 at 10:04 PM, an entry by Nurse ?A' read: .1:1 feed. NAS (No Added Salt) mechanical soft diet/thin liquids. poor appetite.On 12/7/25 at 1:50 PM, an entry by Nurse ?B' read:Resident ate less 0-25% of meal in 16 hours? [sic] Resident has decreased appetite, logged in doctor's book.There was no documentation that the RD had provided nutritional monitoring or assessment/implementation since 10/15/25.On 12/17/25 at 9:45 AM, an interview and record review was conducted with RD ?C'. When asked about their process for evaluating and addressing residents' nutritional risks or impairments, RD ?C' reported concerns with communication between the nutrition and nursing department. RD ?C' further reported they tried their best by looking at progress notes, but that wasn't always clear.When asked about whether they were aware of the residents decline as documented in the progress notes by nursing staff, RD ?C' reported they usually go into the MAR (Medication Administration Record) and make sure the resident is receiving their supplements. RD ?C' reported they had not had a concern for R79 as this was documented as received.When asked what the facility's process was for monitoring weights and what should be done when fluctuations were identified, RD ?C' reported they communicated weight variances within five pounds and sent emails to the Director of Nursing (DON) to obtain re-weights. RD ?C' confirmed there had been no re-weights documented as completed for R79 for the weights identified since October. They were unable to explain why there was no follow-up if the nursing staff had been notified and there was continued concerns with not obtaining re-weights.RD ?C' reported the interdisciplinary team had meetings every morning at 11:00 AM to discuss concerns that included weight fluctuations and need for re-weights. When asked if R79 had been discussed, RD ?C' reported they didn't recall R79 being discussed. When asked if this discussion was documented in the residents' EHR, RD ?C' reported that was not. RD ?C' was asked to confirm their last assessment and confirmed it was 10/15/25. When asked about if there was any other follow-up or monitoring by the RD where would that be located, RD ?C' reported that would be documented in the progress notes and confirmed there was none documented since October. When asked who was responsible for updating the nutritional care plans, RD ?C' reported they did that as well and confirmed the resident's care plan had not been updated to reflect the current decline.On 12/17/25 at approximately 10:05 AM, an interview was conducted with the DON. When asked about their process for obtaining re-weights, the DON reported they would have to defer to their policy. The DON was informed of the interview with RD ?C' and informed of the concerns, but did not offer any further clarification as to the lack of coordination of nutritional monitoring including RD involvement and re-weights. According to the facility's policy titled, Weights: Obtaining dated 12/22/24: .Residents with a weekly weight loss/gain of 5 pounds or more will be re-weighed within 24 hours, aor as ordered by physician, nurse practitioner, physician assistant, or dietitian .Nurse will call provider with weight gain of 3 pound in two days or 5 pounds in one week. Nurse will document notification of weight change in nursing progress note .The Registered Dietician and/or Dietetic Technician, Registered will review resident weights weekly .Dietitian will notify nursing of any weights that vary 5% or 5# or more compared to previous month's weight. See also Administrative Policy N102P Nutrition Status Monitoring.According to the facility's policy titled, Nutritional Status Monitoring dated 8/16/24: .The dietitian will monitor residents' weight and nutritional status, identify any unplanned significant weight change, discuss the etiology of weight changes, and develop and document appropriate interventions both nutritionally and interdisciplinary .The Registered Dietitian (RD) will monitor residents at nutritional risk (residents with .pressure wounds, significant weight changes .) .The dietitian will record actions in the dietary progress note in the EHR until the resident is deemed not at risk .Residents discussed weekly include (but are not limited to) the following .Residents with significant changes in appetite/oral intake .Residents with significant weight changes .Weight change of 5% or greater in past 30 days .

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	12/18/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. This citation pertains to Complaint #2685171. Based on observation, interview, and record review, the facility failed to ensure food was served according to resident preference for one (R122) of one resident reviewed for food, resulting in resident frustration. Findings include:On 12/16/25 at 12:30 PM, during an observation of the lunch meal in the 1 [NAME] dining area, R122 was observed seated at a table with a container of food that was pushed off to the side. R122 reported she was done eating lunch and she did not eat that food because I don't eat pigs. A slice of pork loin was observed in the container. R122 reported the facility kept serving her pork products and she told them she did not eat pigs. R122 reported the staff ordered her chicken tenders after she complained but did not understand why it was not noted to not serve the pork products in the first place. R122 reported that was not the first time and she had been served eggs that had a pork product mixed in before. A review of R122's meal ticket for the lunch meal on 12/16/25 revealed what R122 was served which included Herb roasted pork tenderloin. On 12/17/25 at 2:47 PM, an interview was conducted with Registered Dietician (RD) 'C'. When queried about when a dietary assessment was completed for new admissions and how residents' dietary preferences are communicated to the kitchen, RD 'C' reported she did a dietary assessment within seven days of admission. If a resident expressed a dietary preference prior to that assessment, it was expected that it was communicated to her and the kitchen to ensure the resident received their preferred foods. On 12/17/25 at approximately 3:00 PM, an interview was conducted with the Director of Nursing (DON). The DON reported if a resident expressed a food preference to the nursing staff, it should be communicated to the dietary staff and RD.