STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414090	A. BUILDING _____ B. WING _____	4/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COREWELL HEALTH REHAB & NURSING CENTER - KENTRIDGE	4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508

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F0000 SS=	INITIAL COMMENTS Corewell Health Rehab & Nursing Center was surveyed for an Abbreviated survey on 4/28/25 - 4/29/25. Intakes: MI00152059, MI00152599 Census = 143	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F0550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

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	reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00152599. Based on interview and record review, the facility failed to ensure residents were treated with dignity and respect in 2 (Resident #100, Resident #101) of 4 residents reviewed for abuse, resulting in feelings of diminished self-worth and frustration. Findings include: Resident #100 Review of an "Admission Record" revealed Resident #100 was a male, with pertinent diagnoses which included: diarrhea, anxiety, and cerebral palsy (a disorder that affects movement, muscle tone, or posture). Review of a "Minimum Data Set" (MDS) assessment for Resident #100, with a reference date of 3/5/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15, which indicated Resident #100 was cognitively intact. In an interview on 4/28/25 at 10:05 AM, Resident #100 reported "Certified Nurse Aide" (CNA) "P" had yelled at him because he had an accident. Resident #100 reported he had had a bowel movement accident and CNA "P" came in his room and started yelling because he had had the accident. Resident #100 reported "Licensed Practical Nurse" (LPN) "Q" witnessed the			

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	interaction. In an interview on 4/29/25 at 9:04 AM, LPN "Q" reported he had been in the hall when CNA "P" had been in Resident #100's room. LPN "Q" reported hearing escalating tension in the voices of both Resident #100 and CNA "P" and had gone into the room to deescalate the situation. LPN "Q" reported CNA "P" had a "condescending tone" in the way she was approaching the situation with Resident #100. LPN "Q" reported CNA "P" was projecting the frustration that she felt due to having to clean up Resident #100. LPN "Q" reported it wasn't the words CNA "P" used; it was the tone. LPN "Q" reported CNA "P" would consistently cut Resident #100 off when he was trying to express himself and how he felt. LPN "Q" reported CNA "P" had not been treating Resident #100 with dignity and respect during the interaction. In an interview on 4/28/25 at 11:04 AM, "Social Worker" (SW) "E" reported Resident #100 had complained that CNA "P" had yelled and had a harsh tone with him when she went into his room to change him. In an interview on 4/28/25 at 1:34 PM, SW "D" reported Resident #100 had come to her and said that CNA "P" had raised her voice with him and was yelling at him. SW "D" reported Resident #100 presented as quite upset at how CNA "P" had talked to him and had said he could almost cry. SW "D" reported she reported the incident to "Nursing Home Administrator" (NHA) "A" immediately. In an interview on 4/28/25 at 2:34 PM, NHA "A" reported that she, along with SW "E" and Nursing Supervisor (NS) "I" had talked to Resident #100 following the interaction between himself and CNA "P" and Resident #100 had basically said			

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	that he didn't like how loud CNA "P" talked and that he didn't like her tone but that his needs had been met. In an interview on 4/28/25 at 1:11 PM, CNA "P" reported management had spoken to her because a resident had said they did not like the tone of her voice. CNA "P" reported when she went into Resident #100's room, he was in his wheelchair in the bathroom, and he was upset because he couldn't wait to get on the toilet and had messed himself. CNA "P" reported she kept telling Resident #100 in a regular tone that it was okay and that we were going to get him cleaned up. CNA "P" reported later in the day a manager had told her that Resident #100 had not liked her tone. In a follow-up interview on 4/29/25 at 12:30 PM, Resident #100 reported he felt CNA "P" had not treated him with respect and that he had already been humiliated that he had had an accident in his wheelchair and when CNA "P" started yelling at him, it made him feel even worse. Resident #101 Review of an "Admission Record" revealed Resident #101 was a male, with pertinent diagnoses which included: current mild episode of major depressive disorder and hemiplegia (weakness or paralysis on one side) of left nondominant side as late effect of nontraumatic intraparenchymal hemorrhage (a type of stroke) of brain. Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 3/7/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15, which indicated Resident #101 was cognitively intact.			

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	In an interview on 4/28/25 at 10:27 AM, Resident #101 reported CNA "P" did not treat him with dignity and respect at times. Resident #101 reported CNA "P" had been rude and made him feel little and insignificant 3 or 4 weeks ago when he placed his call light on, and she had come in the room and made him feel like he was a bother to her. Resident #101 reported he had told CNA "P" that he needed to use the restroom, and she had told him he didn't need to go because he had just gone. Resident #101 reported he has had accidents waiting to be toileted.			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0609		

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement policies and procedures for immediate reporting to the State Agency for 1 (Residents #100) of 4 residents reviewed for abuse reporting, resulting in the potential for further instances of abuse going undetected, unreported, or without thorough investigation. Findings include: Review of a "Minimum Data Set" (MDS) assessment for Resident #100, with a reference date of 3/5/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15, which indicated Resident #100 was cognitively intact. In an interview on 4/28/25 at 10:05 AM, Resident #100 stated, "I had one of the aides that verbally abused me." Resident #100 reported he had had a bowel movement accident. Resident #100 reported the aide (CNA "Certified Nurse Aide" "P") had come in his room and started yelling at him because he had had an accident. Resident #100 reported that he had complained to the facility. Resident #100 reported that a nurse (Licensed Practical Nurse, LPN "Q") had witnessed the incident and encouraged him to report it. Resident #100 reported he had told "Social Worker" (SW) "D". Resident #100 reported he had a meeting with "Nursing Home Administrator" NHA "A", SW "E", and "Nursing Supervisor" (NS) "I" shortly after reporting the incident and told them that CNA "P" had yelled at him to which they said they would speak to the CNA. Resident #100 reported he had also reported CNA "P" approximately 3 months earlier for how she had spoken to him. Resident #100			

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	reported at that time, management had also said they would talk to her. In an interview on 4/28/25 at 11:04 AM, SW "E" reported Resident #100 had complained that CNA "P" had gone into his room and had been yelling at him with a harsh tone when he had needed to be changed. SW "E" reported there have been other residents who have complained about CNA "P" in the past. In an interview on 4/28/25 at 11:17 AM, NS "I" reported Resident #100 had concerns with the way CNA "P" had spoken to him. NS "I" reported they had investigated Resident #100's concern and followed up with CNA "P". NS "I" reported he, along with NHA "A", and SW "E" had a conversation with Resident #100 who had reported he didn't feel safe with CNA "P" providing cares to him, so they developed a plan to make Resident #100 feel safe. In an interview on 4/28/25 at 1:34 PM, SW "D" reported Resident #100 had reported to her that CNA "P" had raised her voice with him and was yelling at him. SW "D" reported Resident #100 had soiled himself with bowel movement and was quite upset with how CNA "P" had talked to him. SW "D" reported Resident #100 had said that a nurse had heard CNA "P"'s tone of voice and come into the room. SW "D" reported Resident #100 had said he felt like the incident was abusive and that he felt he could almost cry. SW "E" reported when she heard the word abuse, she reported the incident to NHA "A" immediately. In an interview on 4/28/25 at 2:34 PM, NHA "A" reported after the incident between Resident #100 and CNA "P" had been reported to her, staff, including herself, had spoken to the resident for over an hour. NHA "A" reported Resident #100 had basically said he didn't like how loud CNA			

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	"P" talked and that he didn't like her tone. NHA "A" reported Resident #100 had said he had gotten the cares he needed from CNA "P". NHA "A" reported Resident #100 did not use the word "abuse" when speaking with her. NHA "A" reported normally an incident of this nature would have been put on a grievance form but since it was handled right at the time, a clinical note was entered in the resident's medical record instead. In an interview on 4/29/25 at 9:04 AM, "Licensed Practical Nurse" (LPN) "Q" reported he had witnessed the incident between Resident #100 and CNA "P". LPN "Q" reported he had heard the situation escalating and tension in the voice of Resident #100 and CNA "P", so he went into the room to deescalate the situation. LPN "Q" reported CNA "P"'s tone was condescending. In a follow-up interview on 4/29/25 at 11:24 AM, NHA "A" reported when they had met with Resident #100, he talked about his concerns, but his concern was just how he didn't like how CNA "P" spoke with him and that all his needs were met. NHA "A" reported when they were discussing the incident with Resident #100, she (NHA "A") was under the impression that CNA "P" always talked loudly, and Resident #100 didn't like her tone. NHA "A" reported she felt like meeting with Resident #100 and talking about it with him that he was okay with it. NHA "A" reported immediately after Resident #100 had reported he did not like how CNA "P" talked to him; Resident #100 was taken off CNA "P"'s assignment. In a follow-up interview on 4/29/25 at 1:12 PM, NS "I" reported he had talked to LPN "Q" following the reported incident between Resident #100 and CNA "P" but did not document the conversation.			

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	Review of a "Nursing Note" dated 4/8/25 at 4:00 PM revealed, "Spoke with (Resident #100) regarding his raising concerns about a specific staff member. Building administrator and social worker were present for this conversation. He stated that he had needed to use the restroom and staff had not made it into his room in time to assist him and he had an accident. (Resident #100) expressed frustration with the communication between him and this staff member. (Resident #100) also verbalized that there were no concerns with the cares provided by the staff member during this interaction. Leadership validated (Resident #100)'s feeling and discussed multiple solutions to help prevent this from happening in the future. The first solution included taking (Resident #100) off the float run and assigning him to one of the aides that stays on the unit so that he can receive more timely care. The second was to have two staff members provide cares to (Resident #100) to ensure that communication is always done in a manner that is acceptable to him. (Resident #100) was assured that follow up would be occurring with the specific staff member regarding the situation. (Resident #100) verbalized satisfaction with and appreciation for the follow up occurring. (Resident #100) was encouraged to continue to bring any concerns he has to building leadership to be addressed." There was no evidence of interviews with other residents or other staff conducted to immediately verify that abuse did not occur. Review of the policy "Resident Abuse Program Procedure" effective date 10/30/23 revealed, " ...11. Reporting/response 11.3.1. (State Survey Agency name omitted) reporting: In compliance with Federal law, an immediate report is provided to the Administrator/designee and the State Survey Agency (name omitted) of alleged			

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	violations involving physical, mental, involuntary seclusion and sexual abuse, as well as neglect, mistreatment, misappropriation, and injuries of unknown origin. The Administrator/designee must report to (State Survey Agency name omitted) within two hours. The initial report must provide sufficient information to describe the alleged violation and indicate how the residents are being protected ..."			