

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 4/24/2025
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NAME OF PROVIDER OR SUPPLIER GREENFIELD REHAB AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3030 GREENFIELD AVE ROYAL OAK, MI 48073
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F0000 SS=	INITIAL COMMENTS Greenfield Rehab & Nursing Center was surveyed for an Abbreviated survey on 4/24/25. Intakes: MI0015083, MI00150997, MI00151073, MI00152130 Census=82	F0000		
F0558 SS= E	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00152130. Based on observation, interview, and record review, the facility failed to ensure call lights were within reach of five (R605, R606, R607, R608, and R609) of six residents reviewed for accommodation of needs. Findings include: A review of a complaint submitted to the State Survey Agency revealed an allegation of call lights not being accessible to a resident. On 4/24/25 at 9:25 AM, R605 was observed lying in bed, crying. R605's call light was observed hanging from the head of the bed out of reach from the resident. At that time, Licensed Practical Nurse (LPN) 'F' entered	F0558	F 558 ELEMENT 1 It is the practice of the facility to provide reasonable accommodation of resident needs and preferences to include but not limited to ensuring call lights are within reach for the residents. R605, R606, R607, R608, and R609 call light were relocated to ensure they were within reach before the end of the survey. ELEMENT 2 Residents that currently reside in the facility have the potential to be affected by this cited practice. Those residents have been reviewed to ensure call lights are within reach. Any deficiencies have been immediately corrected. ELEMENT 3 The Interdisciplinary Team reviewed the Call Light policy and deemed it appropriate. Staff have been educated on the Call Light policy with emphasis on ensuring the residents' call lights are within reach. ELEMENT 4 The DON/designee will complete random audits on 5 residents a week for 4 weeks, then 5 residents a month for 2 months to ensure	5/8/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/06/2025

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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	<p>R605's room to speak with the resident. LPN 'F' did not ensure the call light was placed within reach of the resident prior to exiting the room. Then, Registered Nurse (RN) 'G' entered R605's room to assess what was going on. RN 'G' did not ensure the call light was placed within reach of the resident prior to exiting the room.</p> <p>On 4/24/25 at 10:39 AM, R606 was observed in bed sleeping. R606's call light was observed on the floor, underneath the bed, not accessible to the resident. At that time, R607 was observed in bed sleeping. R607's adaptive call light (a special call light designed for people with limited movement in their hands) was observed on the floor, underneath the bed, not accessible to the resident.</p> <p>On 4/24/25 at 11:45 AM, Certified Nursing Assistants (CNAs) were observed providing care to R606.</p> <p>On 4/24/25 at 10:42 AM, R608 was observed in bed sleeping. R608's call light was observed on the floor, tangled with another cord, not accessible to the resident. At 11:37 AM, R608's call light remained on the floor.</p> <p>On 4/24/25 at 10:43 AM, R609 was observed in bed sleeping. R609's call light was observed on the floor, not accessible to the resident.</p> <p>On 4/24/25 at approximately 11:40 AM, CNAs were in R609's room providing care.</p> <p>On 4/24/25 at 12:00 PM, an interview was conducted with RN 'G'. When queried about who was responsible to ensure residents had</p>		<p>call lights are within reach. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting.</p> <p>The Administrator and/or designee is responsible for compliance.</p> <p>Compliance Date: 5/8/25</p>	

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	<p>access to their call lights, RN 'G' reported the CNAs and nurses were responsible. At that time, observations were made of R606, R607, R608, and R609's call lights, which remained on the floor and out of reach of the residents. RN 'G' reported the call lights should always be placed within reach of the residents, especially if care was provided, that was part of providing care.</p> <p>On 4/24/25 at 12:18 PM, an interview was conducted with the Director of Nursing (DON). When queried about who was responsible to ensure residents had access to their call lights, the DON stated, "All of us. The entire nursing team is responsible". The above observations were shared with the DON. The DON reported that should not have happened as the staff were educated twice that week already.</p> <p>A review of R605's clinical record revealed R605 was admitted into the facility on 11//22/22 and readmitted on 3/22/25 with diagnoses that included: encephalopathy and vascular dementia. A review of R605's Minimum Data Set (MDS) assessment revealed R605 had moderately impaired cognition and was incontinent.</p> <p>A review of R606's clinical record revealed R606 was admitted into the facility on 1/13/25 with diagnoses that included: quadriplegia. A review of an MDS assessment dated 1/19/25 revealed R606 had intact cognition and was dependent on staff for all activities of daily living (ADLs).</p> <p>A review of R607's clinical record revealed R607 was admitted into the facility on 11/21/19 and readmitted on 10/12/22 with diagnoses that included: Alzheimer's</p>			

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	<p>Disease. A review of a MDS assessment revealed R607 had severely impaired cognition and required substantial/maximum to total assistance from staff. A review of R607's care plans revealed R607 was at risk for falls and required an adaptive call light that was to be placed at "hip height on pt (patient) right side".</p> <p>A review of R608's clinical record revealed R608 was admitted into the facility on 11/8/24 and readmitted on 12/12/24. A review of R608's care plans revealed R608 was at risk for falls and their call light was to be within reach.</p> <p>A review of R609's clinical record revealed R609 was admitted into the facility on 3/11/22 and readmitted on 1/4/24. A review of a MDS assessment dated 2/26/25 revealed R609 had moderately impaired cognition and required substantial/maximum assistance for bed mobility and transfers and was dependent on staff for toilet transfers. A review of R609's care plans revealed R609 was at risk for falls and their call light was to be within reach.</p>				