STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI00151221 Based on observation, interview, and record review the facility failed to develop and implement person centered care plans for 2 (Resident #1 and Resident #3) of 3 residents reviewed for care plan development and implementation resulting in Resident #1 exiting the facility unsupervised and the potential for Resident #3 to elope from the facility. Findings include: Resident #1 Review of an Facesheet revealed Resident #1 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: unspecified dementia, unspecified mood disorder, unsteadiness on feet, and a need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #1, with a reference date of 1/14/2025 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #1 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). On 6/17/25 at 8:00 am, signage was observed posted on the window next to an emergency exit door near the chapel indicating that residents should not be let out of the building, and to alert staff if a resident is trying to exit the building, and to ensure that the door is closed all of the way after you exit the building. Review of Care Plan for Resident #1 revealed .Problem start dated 6/20/2023 behavioral symptoms at risk for elopement from facility r/t Dx (related to diagnosis of) dementia . Resident #1 engaged alarm at exit door in corridor stating he wanted to leave facility for cigarettes, Resident #1 makes statements that he feels like his family forgot about him and wants to get back to North Carolina . goal Resident will not leave building unattended with a target date of 4/23/25 .approach (interventions) . alarms placed on resident's door for safety (start date 3/14/25), elopement assessment quarterly and PRN (as needed), provide conversation/distraction PRN offer snack/drink, offer music, movie, magazine/book, etc. resident to be in elopement book with photo/information .seek feeling/reason behind resident's actions .when necessary reinforce reason for not leaving the facility without supervision .when resident is pacing/wandering exit seeking, assess for and attempt to provide measure to meet basic needs (hunger, thirst, pain, toileting) . all with a start date of 6/20/23. (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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Elopement Risk Assessment for Resident #1 with a completion date of 8/06/2024 at 3:59 am revealed .1. is the resident physically capable of eloping out of the facility by walking or using an assistive device such as a wheelchair? Answer Yes . 2. Does the resident have a history of wandering or elopement? Answer Yes . 4. Does the resident search for spouse of family? Answer Yes . if the answer to any of the questions 2-7 is yes, the IDT (interdisciplinary team) must implement the Elopement Protocol . In an interview on 6/17/25 at 9:13 am Nursing Home Administrator (NHA) A provided surveyor with an investigation report, and reported Resident #1 did elope from the building on 2/28/25. NHA A reported Resident #1 was last seen on 2/28/25 by an employee of the activity department at approximately 1:45 pm when they returned to the facility following an outing, and that Resident #1 was last seen approximately 15 minutes before being found outside by his assigned CNA (certified nursing assistant) J. In an interview on 6/17/25 at 10:18 am, Business Office Manager (BOM) F reported she left the facility in her car on the afternoon of 2/28/25, and when she exited the facility driveway onto the road, she observed Resident #1 walking alone along the road. BOM F reported she stopped, asked Resident #1 what he was doing to which he replied, going to get cigarettes BOM F assisted him into her car and drove to the front entrance and escorted Resident #1 back into the building approximately 3:30 pm. In an interview on 6/17/25 at 10:44 am Licensed Practical Nurse (LPN) S reported Resident #1 loved to walk to the door and look out at the white cars in the parking lot. LPN S reported that Resident #1 did push on the doors from time to time setting off the alarms. In an interview on 6/17/25 at 12:07 pm, Activities Assistant (AA) D reported Resident #1 was amazed by white cars and spent significant time looking out the window at white cars. AA D reported that Resident #1 would drift off to get a better look at a white car. In an interview on 6/17/25 at 12:43 pm, CNA I reported that Resident #1 had a routine where he would check the doors, he would look outside, push on the door, and engage the alarm. CNA I reported that Resident # 1 was trying to exit the building when he was checking the doors. In an interview on 6/17/25 at 1:27 pm, Activities Director (AD) E reported she would take Resident #1 on walks in the parking lot when he wanted to look at the white cars. AD E reported it was important to monitor resident's whereabouts if they were elopement risks. When asked how staff knew Resident #1 needed to be monitored for elopement risk, AD E reported the staff just knew when to do it. In an interview on 6/17/25 at 1:54 pm CNA K and CNA M reported that Resident #1 enjoyed checking the doors and looking out the window at white cars in the parking lot. CNA M reported Resident #1 looked for white cars in the parking lot almost every day. In an interview on 6/17/25 at 2:25 pm Housekeeping Supervisor (HS) R reported that Resident #1 looked out the window at the cars in the parking lot frequently. In an interview on 6/17/25 at 2:30 pm, CNA O reported that Resident #1 was obsessed with white cars and loved to look out the window. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/18/25 at 10:26 am, Social Service Director (SSD) X reported Resident #1 was fascinated with white vehicles and cigarettes. SSD X reported she recalled that Resident #1 was trying to get to town to get cigarettes when he eloped from the building. SSD X reported Resident #1 had a pattern of wanting to look out the window at the white cars. SSD X reported that Resident #1's guardian had granted privileges for Resident #1 to go outside to smoke to curtail his behaviors of exit seeking. SSD X reported that Resident #1 would ask where home was, to go outside to smoke, and to see the white cars in the parking lot; SSD X reported staff would know his behavior was ramping up and Resident #1 would need to be watched closely. SSD X reported when Resident #1 verbalized wanting to go out and look at cars or wanting cigarettes he was placed on 15- or 30-minute checks. When queried if Resident #1's change in behavior towards leaving the building, fixation on white cars and cigarettes, pattern of looking out the windows, specifically asking where home was and to go outside to smoke, and the ramping up of exit seeking behaviors was noted, documented, monitored, or communicated with all staff, SSD X stated I don't know if we captured it in his record. In an interview on 6/18/25 at 1:32 pm Director of Nursing (DON) B reported every resident in the building was on behavior monitoring and it was a blanket order that was standardized, nothing was specific or individualized to residents. DON B reported that Resident #1 did not have specific interventions in his care plan related to his specific behaviors. DON B stated we don't monitor behaviors, no one was told to monitor Resident #1 as his behaviors escalated. DON B reported Resident #1 liked white cars and was fixated on cigarettes. At 1:45 pm on 6/18/25, during the interview with DON B; NHA A entered the office, joined the interview and stated, Resident #1 used to sit at the window and watch cars, specifically, white cars. When DON B was queried, if Resident #1's fixation on white cars or cigarettes was noted in his care plan anywhere for staff to reference, DON B stated No paused and then stated Oh, I see where this is going. Resident #3 Review of an Facesheet revealed Resident #3 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: unspecified dementia. Review of a Minimum Data Set (MDS) assessment for Resident #3, with a reference date of 6/9/2025 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #5 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). Review of Care Plan for Resident #3 revealed .Problem start dated 3/20/2025 At risk for elopement form the facility r/t impaired cognition .goal Resident will not leave building unattended .approach (interventions) . elopement assessment quarterly and PRN (as needed), provide conversation/distraction PRN offer snack/drink, offer music, movie, magazine/book, etc. resident to be in elopement book with photo/information .resident to be on designated timed checks .seek feeling/reason behind resident's actions .when necessary reinforce reason for not leaving the facility without supervision .when resident is pacing/wandering exit seeking, assess for and attempt to provide measure to meet basic needs (hunger, thirst, pain, toileting) . all with a start date of 3/20/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Elopement Risk Assessment for Resident #3 with a completion date of 2/28/25 at 4:04 pm revealed .1. is the resident physically capable of eloping out of the facility by walking or using an assistive device such as a wheelchair? Answer Yes . 2. Does the resident have a history of wandering or elopement? Answer Yes . 3. Does the resident verbalized the desire to leave the facility or return home? Answer Yes .4. Does the resident search for spouse of family? Answer Yes . 6. Has the resident stood or sat at a locked door waiting for someone to let them out when they go through the door? Answer Yes 7. If the answer to the last question is Yes, has the resident attempted to go out the door unattended? Answer Yes .if the answer to any of the questions 2-7 is yes, the IDT (interdisciplinary team) must implement the Elopement Protocol . In an interview on 6/17/25 at 1:12 pm, Registered Nurse (RN) Y reported there was only one resident in the facility that was an elopement risk. RN Y did not name Resident #3. In an interview on 6/17/25 at 1:20 pm LPN S reported that Resident #3 was an elopement risk, and she had a pattern of looking for family in the evening but there was no resident who would exit seek in the building. Review of Elopement Book located on the [NAME] Nurse's station revealed Resident #3's picture was in the book and was noted that Resident #3 would look for her mother. In an interview on 6/17/25 at CNA H reported she worked on the EAST unit, and there were no residents who were elopement risks at this time. In an interview on 6/17/25 at 1:54 pm, CNA K reported that Resident #3 would look for her family in the evening. In an interview on 6/17/25 at 2:00 pm, LPN T reported the staff did not monitor residents for behaviors, did not have behavior logs, and she was not aware of any residents who had specific care plan interventions in place. In an interview on 6/18/25 at 12:30 pm, LPN S reported floor nurses create the baseline care plan, but any specific interventions were done by the leadership nurses and MDS nurse. In an interview on 6/18/25 at 12:24 DON B reported all the nurses were responsible for care plan interventions but Minimum Data Set (MDS) V nurse was ultimately responsible to create resident care plans. In an interview on 6/18/25 at 12:45 pm MDS V reported he was responsible for the creation of care plans and the interventions. MDS V reported he used the computer program to create the care plan from a template. MDS V reported the preference of the facility was to use pre-selected interventions and not create interventions. MDS V reported care plans should be resident specific and individualized and the pre-selected care plans were not resident specific nor individualized. MDS V reported there was an area in the template care plans where text could be entered but that they do not typically customize interventions. In an interview on 6/18/25 at 1:25pm Unit Manager/Licensed Practical Nurse (UM/LPN) Z reported most care plans were templates. UM/LPN Z reported the care plan could be customized or added to if needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/18/25 at 1:32 pm DON B reported the facility did not monitor behaviors and Resident #3 was not being monitored. DON B reported there was not specific interventions in Resident #3's care plan related to elopement risk.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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: MI00151221 Based on observation, interview, and record review the facility failed to ensure the safety and prevent an elopement of 1 (Resident #1) of 2 residents who were assessed to be at risk for elopement, resulting in an Immediate Jeopardy when Resident #1 left the premises alone, unbeknownst to staff, and was later observed (by a staff member who happened to drive by) walking along the road on 2/28/25, and was returned to the facility at approximately 3:30 pm. The elopement placed Resident #1 at risk serious harm, serious injury, and/or death. Findings include: The facility failed to ensure the safety and prevent an elopement of Resident #1 who left the premises unbeknownst to staff and was observed walking alone along the road by a staff member on 2/28/25, placing Resident #1 at risk for and resulted in the likelihood for serious harm, injury, and/or death. Nursing Home Administrator A was notified of the Immediate Jeopardy on 6/17/25 at 1:05 pm. The surveyor confirmed by observation, interview, and record review, that the Immediate Jeopardy was removed on 2/28/25, and the deficient practice corrected, on 3/4/25, prior to the start of the survey and was therefore past noncompliance. Review of an Facesheet revealed Resident #1 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: unspecified dementia, unspecified mood disorder, unsteadiness on feet, and a need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #1, with a reference date of 1/14/2025 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #1 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). At facility entrance on 6/17/25 at 7:35 am, signage was observed posted on the window next to the front entrance door indicating that residents should not be let out of the building, and to alert staff if a resident is trying to exit the building, and to ensure that the door is closed all of the way after you exit the building. On 6/17/25 at 8:00 am, signage was observed posted on the window next to an emergency exit door near the chapel indicating that residents should not be let out of the building, and to alert staff if a resident is trying to exit the building, and to ensure that the door is closed all of the way after you exit the building. On 6/17/25 at 8:03 am, signage was observed posted on the window next to the front entrance door indicating that visitors attempting to exit the building needed staff assistance to open the door and to not push on the door unless it was an emergency. Medical Records (MR) W was observed approaching the front entrance door to enter a code and allowed someone (a visitor) into the building after the visitor pulled on the door from the outside and activated the alarm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 6/17/25 at 9:13 am Nursing Home Administrator (NHA) A provided surveyor with an investigation report, and reported Resident #1 did elope from the building on 2/28/25. NHA A reported Resident #1 was last seen on 2/28/25 by an employee of the activity department at approximately 1:45 pm when they returned to the facility following an outing, and that Resident #1 was last seen approximately 15 minutes before being found outside by his assigned CNA (certified nursing assistant) J. In an interview on 6/17/25 at 10:18 am, Business Office Manager (BOM) F reported she left the facility in her car on the afternoon of 2/28/25, and when she exited the facility driveway onto the road, she observed Resident #1 walking alone along the road. BOM F reported she stopped, asked Resident #1 what he was doing to which he replied, going to get cigarettes BOM F assisted him into her car and drove to the front entrance and escorted Resident #1 back into the building approximately 3:30 pm. Review of Care Plan for Resident #1 revealed .Problem start dated 6/20/2023 behavioral symptoms at risk for elopement from facility r/t Dx (related to diagnosis of) dementia . Resident #1 engaged alarm at exit door in corridor stating he wanted to leave facility for cigarettes, Resident #1 makes statements that he feels like his family forgot about him and wants to get back to North Carolina . goal Resident will not leave building unattended with a target date of 4/23/25 .approach (interventions) . alarms placed on resident's door for safety (start date 3/14/25), elopement assessment quarterly and PRN (as needed), provide conversation/distraction PRN offer snack/drink, offer music, movie, magazine/book, etc. resident to be in elopement book with photo/information .seek feeling/reason behind resident's actions .when necessary reinforce reason for not leaving the facility without supervision .when resident is pacing/wandering exit seeking, assess for and attempt to provide measure to meet basic needs (hunger, thirst, pain, toileting) . all with a start date of 6/20/23. Review of Elopement Risk Assessment for Resident #1 with a completion date of 8/06/2024 at 3:59 am revealed .1. is the resident physically capable of eloping out of the facility by walking or using an assistive device such as a wheelchair? Answer Yes . 2. Does the resident have a history of wandering or elopement? Answer Yes . 4. Does the resident search for spouse of family? Answer Yes . if the answer to any of the questions 2-7 is yes, the IDT (interdisciplinary team) must implement the Elopement Protocol . Review of Investigation authored and provided by NHA A on 6/17/25 revealed .at approximately 3:30 pm Resident #1 was observed by BOM F walking down the street. The BOM F was going to the bank. Resident #1 was wearing long pants, long sleeved shirt, and a winter jacket. Resident #1 is independent and ambulatory with a cane. Resident #1 was immediately assisted into BOM F's car and was brought back to the facility. Resident #1 hands were not cold .the weather at the time Resident #1 was brought back inside was 42 degrees Fahrenheit .Resident #1 was last seen by CENA (CNA) approximately 15 minutes before he was found outside .Resident recently started to have the ideation of smoking and does not remember that the facility stores his cigarettes in a lock box .Resident was identified as an elopement risk on 11/18/2024, the elopement protocol was implemented, and the resident was identified in the elopement book . Review of Investigation Statement dated 2/28/25 revealed Certified Nursing Assistant (CNA) J was the assigned CNA to Resident #1 when he eloped from the building. CNA J reports that he last seen the resident approximately 15 minutes before he was found outside, and CNA J was immediately assigned to 1:1 supervision of Resident #1 when he was returned to the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Repeated attempts to contact CNA J were unsuccessful. No contact was made with CNA J by the time of survey exit. In an interview on 6/17/25 at 10:44 am Licensed Practical Nurse (LPN) S reported Resident #1's room was directly across the hall from the nurse's station and that Resident #1 loved to walk to the door and look out at the parking lot. LPN S stated he frequently looked out the window at the cars in the parking lot. LPN S reported that Resident #1 did push on the doors from time to time setting off the alarms. LPN S reported Resident #1 got out of the building, and no one knew he was missing, he was found and brought back. On 6/17/25 from 10:45 am to 11:00 am this surveyor walked the facility property, along the roadway where Resident #1 was located by staff on 2/28/25. This surveyor observed that directly in front of the facility, along the roadway there was no sidewalk, the sidewalk was present across the street only. The road was a two-lane divided highway with a turn lane (total of 3 lanes) with a speed limit of 35 MPH (miles per hour). In an interview on 6/17/25 at 12:07 pm, Activities Assistant (AA) D reported he didn't know anything about Resident #1 getting out of the building. AA D reported Resident #1 had been on the activity department outing for lunch on 2/28/25. AA D reported he had accompanied Resident #1 back to his room when they returned from the outing because he (Resident #1) doesn't remember how to get there (to his room). AA D reported he left Resident #1 in his room at about 1:30 pm that day. AA D reported that Resident #1 was amazed by white cars and spent significant time looking out the window at white cars. AA D reported that Resident #1 would drift off to get a better look at a white car, and that Resident #1 was known to slip away and walk down the street when on an outing. AA D reported Resident #1 would be fascinated by things and would follow his interest. In an interview on 6/17/25 at 12:43 pm, CNA I reported that Resident #1 would come out of his room to check the doors. CNA I reported that staff referred to Resident #1 as our security and he would walk to the doors, look outside, push on the doors and when the alarm sounded, he would back away. When queried if Resident #1 did that often, CNA I stated Yes, he always did that, it was his routine to check the doors. When further queried about why Resident #1 would check the doors CNA I stated he was trying to get out. In an interview on 6/17/25 at 1:27 pm, Activities Director (AD) E reported she would take Resident #1 on walks in the parking lot when he wanted to look at the white cars. AD E reported it was important to monitor resident's whereabouts if they were elopement risks, and she would encourage activity participation to keep an eye on residents who were elopement risks. In an interview on 6/17/25 at 1:37 pm, CNA H reported that Resident #1 was on normal every 2 hour checks before he eloped from the building and was placed on 15-minute checks after he eloped. In an interview on 6/17/25 at 1:54 pm CNA K and CNA M reported that Resident #1 enjoyed checking the doors and looking out the window at white cars in the parking lot. CNA M reported Resident #1 looked at white cars in the parking lot almost every day. In an interview on 6/17/25 at 2:25 pm Housekeeping Supervisor (HS) R reported that Resident #1 looked out the window at the cars in the parking lot frequently. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 6/17/25 at 2:30 pm, CNA O reported that Resident #1 was obsessed with white cars and loved to look out the window. In an interview on 6/18/25 at 9:35 am, Maintenance Supervisor (MS) U reported he checks the door alarms to every door in the building daily. There was no inoperable door alarm when Resident #1 eloped from the building. MS U reported that Resident #1 would stand at the window at the end of the west hall facing the parking lot and talk about all of the white cars in the parking lot. MS U reported that Resident #1 would push on the door and set off the alarm and then when the alarm sounded, he would back away from the door. In an interview on 6/18/25 at 10:26 am, Social Service Director (SSD) X reported Resident #1 was fascinated with white vehicles and cigarettes. SSD X reported she recalled that Resident #1 was trying to get to town to get cigarettes when he eloped from the building. SSD X reported that Resident #1 would go through spurts when he would want to leave the building. SSD X reported Resident #1 had a pattern of wanting to look out the window at the white cars and was fixated on cigarettes. SSD X reported that Resident #1 would go outside supervised with AD E to smoke. SSD X reported that Resident #1's guardian had granted privileges for Resident #1 to go outside to smoke to curtail his behaviors of exit seeking. SSD X reported that Resident #1 was quiet, but his mood would change, and Resident #1 would ask where home was, to go outside to smoke, and to see the white cars in the parking lot; SSD X reported staff would know his behavior was ramping up and Resident #1 would need to be watched closely. SSD X reported when Resident #1 verbalized wanting to go out and look at cars or wanting cigarettes he was placed on 15- or 30-minute checks. When queried if Resident #1's change in behavior towards leaving the building, fixation on white cars and cigarettes, pattern of looking out the windows, specifically asking where home was and to go outside to smoke, and the ramping up of exit seeking behaviors was noted, documented, monitored, or communicated with all staff, SSD X stated I don't know if we captured it in his record. When further queried, SSD X reviewed Resident #1's medical record and reported she did not locate any documentation that Resident #1 had increased behaviors or had been placed on 15- or 30- minute checks in the six months prior to his elopement from the building. SSD X reported the IDT team discussed Resident #1's elevated mood in morning meeting and the nursing staff was notified of Resident #1's elevated mood in a text message. When queried what information the nursing staff text message contained, SSD X stated I don't know about that, because I am not included. SSD X reported the communication to staff for increased supervision for Resident #1 was verbal. SSD X reported when a resident has specific behaviors, those behaviors should be documented, and the monitoring of behavior occurrences should be documented in the resident records. SSD X reviewed Resident #1's record and reported there was no documentation of monitoring specific behaviors and no indication that Resident #1 needed increased supervision until 2/28/25 when he was found alone outside of the building and was placed on one-to-one supervision. Review of Resident #1's medical record revealed no noted specific behaviors that Resident #1 displayed, nor any behavior monitoring. Requested behavior logs from NHA via email on 6/18/25 at 11:58 am. On 6/18/25 at 1:16 pm NHA A replied in an e-mail to the request for Resident #1's behavior logs any changed in behavior from baseline would be noted in a progress note. No behavior logs for Resident #1 were provide by the facility by the time of exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 6/18/25 at 1:25 pm, Unit Manager/Licensed Practical Nurse (UM/LPN) Z reported she did not have anything to do with behavior monitoring. UM/LPN Z reported behavior monitoring was not specific for residents; it was a standing order that was triggered at admission. In an interview on 6/18/25 at 1:32 pm Director of Nursing (DON) B reported every resident in the building was on behavior monitoring and it was a blanket order that was standardized, nothing was specific or individualized to residents. DON B reported that Resident #1 did not have specific interventions in his care plan related to his specific behaviors. DON B stated we don't monitor behaviors, no one was told to monitor Resident #1 as his behaviors escalated. DON B reported Resident #1 liked white cars and was fixated on cigarettes. At 1:45 pm on 6/18/25, during the interview with DON B; NHA A entered the office, joined the interview and stated, Resident #1 used to sit at the window and watch cars, specifically, white cars. When DON B was queried, if Resident #1's fixation on white cars or cigarettes was noted anywhere for staff to reference, DON B stated No paused and then stated Oh, I see where this is going. The Immediate Jeopardy began on 2/28/25 was removed on 2/28/25 when the facility took the following actions to remove the immediacy: 1) Resident #1 was assessed immediately upon being brought into the facility. It was documented as follows: progress note for DON B on 2/28/25 at 5:34 pm, elopement risk assessment on 2/28/25 at 4:08 pm, skin assessment on 2/28/25 at 5:20 pm, pain assessment on 2/28/25 at 5:46 pm. Resident #1 demonstrated no injuries. Resident #1 did not appear to be in psychosocial distress. SSD X sent referral to nearby memory care units with guardian's permission on 3/3/25. 2) Resident #1 was immediately placed on a 1:1 on 2/25/25 at 4:08 pm. Resident #1 remained on 1:1 supervision until 3/14/25 when the 1:1 was removed for third shift only. Resident was placed on q15 (every 15) minute checks for third shift on 3/14/25. Administrator also placed alarms on Resident #1's door for safety. On 3/17/25 Resident #1 was placed on q15 minute checks for all shifts with IDT monitoring and no exit seeking behavior. 3) On 3/24/25, a nearby memory care unit accepted Resident #1 and he was discharged from the facility at approximately 10:05 am. 4) Facility completed elopement assessments on all other residents on 2/28/25 with no new residents identified at the time as a risk. 5) Administrator, DON, and Social Service Director audited elopement book for accuracy on 2/28/25 and implemented a weekly audit to ensure compliance with elopement policy and procedures. 6) Interdisciplinary team discussed elopement policy and procedures in ADHOC QAPI on 2/28/25 and monthly QAPI on 3/27/25 to ensure elopement policy and procedures were in place and effective. 7) Signage posted on all EXIT doors on 2/28/25 by administrator at approximately 5 pm to indicate to all visitors to ensure no resident exit the building and to ensure the door is closed completely before leaving the area. 8) All residents were reassessed on 2/28/25 and no additional residents were identified as elopement risks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9) All door alarms were checked and functioning properly on 2/28/25 at approximately 5 pm by the Maintenance Director. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included 1) All staff were educated on the elopement policy and procedure, elopement identification and additional resources to prevent elopements on 2/28/25. The current staff at the facility were educated immediately in person by the administrator. Administrator posted to this education to all staff on the Group Me application (an application that allows for mass messages to be sent and received on phones and/or electronic devices to many different recipients at one time) on 2/28/25 at 7:30 pm. An education binder with all education material was also placed at the EAST nurses' station. As new staff is hired, they will continue to be educated on these policies and procedures. 2) The facility's plan for when a resident is exit seeking is to notify their immediate supervisor who will then notify the DON and/or Administrator. Staff were educated this is something to report immediately. Staff was educated on the possible reasons for elopement and the possible strategies for avoiding such behavior. Staff was also educated on the expectations of being assigned the person doing the 1:1 supervision. 3) Periodically conduct elopement drills for all staff to ensure competency and effectiveness of all staff education on elopements. Quarterly elopement drills will be conducted. The first drill occurred on 4/1/25. 4) Weekly audits of the elopement book starting on 2/28/25 to monitor any current or new identified elopement risk residents. 5) Continued daily door alarm checks to ensure the door alarms are functioning properly to prevent further elopements. 6) Initial social service assessment and quarterly psychosocial assessments completed to ensure any newly identified elopement risk residents have effective interventions in place. 7) Door codes will continue to be changed monthly. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.