STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235281	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearstream Rehabilitation and Nursing Center	240 E North St Hastings, MI 49058

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 This citation pertains to intakes MI00146152, MI00146926 Based on interview, and record review, the facility failed to protect the residents right to be free from resident to resident abuse for 4 (Resident #102, Resident #103, Resident #107 and Resident #108) of 5 residents reviewed for abuse, resulting in Resident #102 physically assaulting Resident #103, and Resident #107 grabbing Resident #108 in a sexual manner. Findings include: Resident #102 Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (a group of thinking and social symptoms that interfere with daily functioning). Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 6/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #102 was severely cognitively impaired. Section E revealed Resident #102 exhibited physical behavioral symptoms directed toward others during 1-3 days of the assessment period and wandered daily. Review of a Care Plan for Resident # 102, with a reference date of 7/10/24, revealed a focus/goal/interventions of: Focus: Resident has potential to be physically aggressive r/t (related to) Dementia with behavioral disturbances .Goal: Resident will not harm self or others .Interventions: When resident becomes agitated: intervene before agitation escalates; guid away from source of distress .report IMMEDIATELY any s/sx (signs and symptoms) of resident posing danger .to others. Review of a Behavior Log revealed Resident #102 exhibited wandering, abusive language, and threatening behavior in the days prior to the assault on Resident #103 on 7/9/24. In an interview on 9/11/24 at 9:16am, Family Member (FM) CC reported Resident #102 had several episodes of physical aggression that were directed toward staff and other residents. FM CC reported she and her daughter asked the facility to evaluate and change Resident #102's medications to reduce his physically aggressive behaviors. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #103 Review of an Admission Record revealed Resident #103, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified intellectual disability, adjustment disorder with depression (strong emotional reaction to a change in life), and dementia. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 8/19/24 revealed Resident #103 could not complete a Brief Interview for Mental Status due to his cognitive limitations. Section C revealed Resident #103 had short- and long-term memory issues but could recall the location of his room and the names and faces of staff. Section E revealed the resident had no behavioral issues during the 14-day assessment period. Review of a Care Plan for Resident # 103, with a reference date of 8/23/22, revealed a focus/goal/interventions of: Focus: Resident has mood concern r/t (related to) intellectual disability. Goal: Resident will exhibit indicators of depression, mania, anxiety or sad mood less than daily by next review. Interventions: When conflict arise, remove resident to a calm safe environment and allow to vent/share feelings .behavioral health consults as needed .monitor/record/report mood to MD (Doctor of Medicine) . Review of a Incident Investigation Report with a reference date of 7/9/24 revealed while in his room, Resident #103 was struck with a closed fist several times by Resident #102. Review of a History of Present Illness report from the contractual behavioral health services for the facility, with a reference date of 7/10/24, revealed Behavior log over the past month is unremarkable. Yesterday he was physically attacked by another resident when he was sleeping in bed .complained of left should pain and was scared and sad after the event. In an interview on 9/11/24 at 3:26pm, Certified Nursing Assistant (CNA) E reported on 7/9/24 at approximately 10:45am, she was assisting a resident with a shower in the shower room that shares a wall with Resident #103's room. CNA E reported she heard blood curdling screams coming through the wall and ran to help. CNA E reported she was the first staff member to arrive and saw Resident #102 standing over Resident #103, who was sat on the end of his bed. CNA E reported she saw Resident #102 strike Resident #103 on both sides of his upper body at least 5 times with a closed fist. Resident #103 had his arms up over his face and was slumped forward. CNA E got in between the 2 residents and when she did, Resident #103 clung to her. Additional staff arrived and CNA E removed Resident #103 from the room. CNA E reported Resident #103 sobbed after the incident and even after he stopped crying, he appeared scared. In an interview on 9/12/24 at 3:05pm, Certified Nursing Assistant (CNA) M reported she responded to the altercation between Resident #102 and Resident #103 and saw Resident #103 with his arms up covering his face. CNA M reported Resident #103 emotional upset, crying and had reddened areas on his upper torso. Review of a Social Services Progress Note with a reference date of 7/9/24, at 13:10pm, revealed when asked if he was alright, Resident #103 rubbed his left shoulder and indicated he was in pain. Review of a Skin Observation Shower Sheet for Resident #103, with a reference date of 7/15/24, revealed he had a fading yellowish bruise on his left shoulder. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #103 was not able to answer questions during an attempted interview on 9/11/24 at 9:16am. In an interview on 9/11/24 at 3:17pm, Legal Guardian (LG) FF reported she received a telephone call on 7/9/24 from the facility and was told Resident #103 was hit by another resident several times. LG FF reported Resident #103 was not able to expressive his thoughts and feelings well, but no one would want to be treated that way and it was the facility' responsible to maintain his safety, and ensure he was not abused. LG FF reported she wondered if Resident #103 should move to another facility after that incident. Using the reasonable person concept, though Resident #103 had decreased ability to verbally express his own thoughts due to his cognitive deficits, he clearly experienced emotional distress and pain following the physical abuse that occurred on 7/9/24. This emotional distress has the potential to continue well past the date of the incident based on the reasonable person concept. Resident #107 Review of an Admission Record revealed Resident #107, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia (a group of thinking and social problems that interfere with daily functioning), and cognitive communication deficit (difficulty with communication caused by a disruption in cognitive processes, such as memory, attention, or problem solving). Review of a Minimum Data Set (MDS) assessment for Resident #107, with a reference date of 9/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #107 was severely cognitively impaired. Section E revealed Resident #107 exhibited physical behavioral symptoms directed toward others (e.g hitting, kicking .grabbing, abusing others sexually) during 1-3 days of the assessment period. Review of a Care Plan for Resident #107, with a reference date of 6/18/19, revealed a focus/goal/interventions of: Focus: (Resident #107) has potential to be .socially inappropriate .has the potential to be inappropriate with touch towards other residents. Goal: (Resident #107) will verbalize understanding of need to control .behavior through the review date as well as not touch other residents. Interventions: Encourage resident to sit at table with men for meals .monitor behaviors. Review of an Incident Investigation Report with a reference date of 9/10/24, revealed CNA (Certified Nursing Assistant U) witnessed (Resident #107) reach out and grab (Resident #108's) bottom as she was walking past him in the dining room. Attempts to contact CNA U were not successful during the survey. Resident #108 Review of an Admission Record revealed Resident #108, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: mild intellectual disabilities (developmental disorder that affects a person's intellectual functioning and adaptive behaviors). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of 8/2/24 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #108 was moderately cognitively impaired. Section I of the MDS revealed Resident #108 was diagnosed with bipolar disorder (disorder associated with mood swings ranging from depressive lows to manic highs) and major depressive disorder (persistent depressed mood). Review of a Care Plan for Resident #108, with a reference date of 10/31/23, revealed a focus/goal/interventions of: Focus: Resident has mood concern r/t (related to) depression. Goal: Resident will participate in decision making and care activities as able .Intervention: Administer medications as ordered, monitor/document .effectiveness. Review of a General Progress Note for Resident #108, written by Registered Nurse (RN) Q on 9/10/24 at 7:00pm, revealed This resident was taken to a private room and asked what happened. She stated that a man had grabbed her butt. This staff nurse asked if she was ok, and she stated no. Resident #108 reported she did not feel safe and did not want to see the man again. The resident was moved to a private room on another unit for the night. Review of a Social Services note for Resident #108 dated 9/11/24 at 5:15pm, revealed a day after Resident #107 grabbed Resident #108, she remained upset, was concerned the resident was looking into her room and decided she wanted to move to another hallway. In an interview on 9/17/24 at 9:36am, Resident #108 a man (named Resident #107) recently grabbed her bottom while she was in the dining room and the incident made her angry enough that I wanted to fight back. Resident #108 reported she cried after the incident because she was very stressed. Resident #108 reported when the incident happened, she felt scared and sad as well. Resident #108 reported after the incident, she decided to move to a different hallway permanently, and to change her seating assignment in the dining room so she wouldn't be close to Resident #107. In an interview on 9/17/24 at 12:15pm, Registered Nurse (RN) Q reported she went to Resident #108 immediately after Certified Nursing Assistant (CNA) Q told her about the incident involving Resident #107 grabbing Resident #108's bottom. RN Q described Resident #108 as pretty shaken up at the time. RN Q reported Resident #108 told her she did not feel safe, was scared to see Resident #107 and ultimately was assisted with going to another room for the night. RN Q reported she had cared for Resident #107 for nearly 2 years and had seen the resident exhibit sexually inappropriate behaviors toward others when he had an acute illness. When further queried, RN Q reported Resident #107 who was acutely ill at the time of the incident, grabbed RN Q in a sexually inappropriate manner prior to the resident's dinner time on 9/10/24. When further queried, RN Q reported she was not aware of any steps that were been taken to ensure the safety of the female residents that Resident #107 would encounter in the dining room that evening. Review of the facility's Abuse and Neglect policy with a reference date of 7/11/18 revealed: POLICY: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse .Definitions of Abuse .Physical: Physical abuse includes but not limited to infliction of injury that occur other than by accidental means, examples: hitting .grabbing .punching .Sexual: Sexual abuse includes but is not limited to harassment .or sexual assault.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 This citation pertains to intake # MI00146924. Based on interview and record review, the facility failed to ensure proper post-fall care and assessment for 1 (Resident #106) of 3 residents reviewed for falls, resulting in the potential for serious injury. Findings include: Review of the facility's Fall-Care and Treatment policy with a reference date of 7/11/18 revealed Policy: It is the policy of this facility to evaluate extent of injury after a fall, prevent complications and to provide emergency care. Procedure: 1. Resident will not be moved until a nurse evaluates the resident's condition. Review of Post-Fall Assessments, published by the American Association of Post-Acute Care Nursing, August 2021, revealed Before a resident can be moved, the nurse must assess them for an injury to the spinal column, obvious fractures, significant bleeding . Review of an Admission Record revealed Resident #106, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral infarction (stroke), major depressive disorder, unspecified dementia, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 7/16/24 revealed Resident #106 could not complete a Brief Interview for Mental Status due to her level of dementia. Section GG of the MDS revealed Resident #106 required maximal assistance (helper does more than half the effort) to transfer from bed to wheelchair. Review of a Care Plan for Resident # 106, with a reference date of 1/12/21, revealed a focus/goal/interventions of: Focus: Resident at risk for falls r/t (related to) end stage dementia. Goal: Resident will remain free from fall related injury .Interventions .follow fall protocol . Review of an Investigation Summary with a reference date of 8/28/24 revealed: (Resident #106) was being transferred via lift following care plan with proper sling .the lift sling came detached and resident fell to floor . (Resident #106) sent to hospital .returned .with stitches to the laceration to the back of her head and a hematoma. In an interview on 9/13/24 at 9:33am Certified Nursing Assistant (CNA) X reported on 8/28/24 Resident #108 fell from sling of the mechanical lift during a transfer and hit her head twice. CNA X reported as Resident #108 laid on the floor with a significant amount of blood coming from a head wound, she panicked and picked the resident up and placed her back in bed. CNA X stated I never should have done that because I could have made her injuries worse. When further queried, CNA X confirmed that a nurse had not assessed Resident #106 for injuries prior to her lifting the resident off the floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/13/24 at 11:30am, Licensed Practical Nurse (LPN) V reported she responded to Resident #108's room on 8/28/24 after the resident fell . LPN V reported Resident #108 was lying on her back in her bed when she arrived. Blood was pooled on Resident #108's pillow under her head and there was blood all over the room. LPN V confirmed at that time that Resident #108 had been moved off the floor before she was properly assessed by a nurse. LPN V reported proper post-fall care included not moving the resident after a fall until a nurse assessed their injuries because moving a resident immediately after a fall could result in a worsening of their injuries, especially after a fall with a head injury because there's a greater likelihood of a spinal cord injury. In an interview on 9/13/24 at 2:14pm, Certified Nursing Assistant (CNA) T reported she was the first staff member to respond on 8/28/24 after Resident #108 fell and CNA X began yelling for help. CNA T reported when she arrived, Resident #108 was lying in bed on her back. CNA T reported there was a significant amount of blood on the floor as well as on the pillow under Resident #108's head. CNA T reported she asked CNA Q what happened, and CNA Q said the resident fell on the floor and she picked the resident up and placed her in bed. CNA T reported the proper protocol to follow when a resident fell , was to leave them in the position they were in and allow a nurse to assess them for injuries before attempting to move them. In an interview on 9/17/24 at 4:09pm, Director of Nursing (DON) B reported it was crucial during post-fall care to leave a resident in the position in which they were found after a fall until they were assessed by a nurse. DON B confirmed that a resident who was moved prior to proper assessment, could suffer complications of their injuries.

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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** 46999 This citation pertains to intakes: MI00146150, MI00146185, MI00146924 This citation has 2 deficient practice statements. DPS #1: Based on observation, interview, and record review, the facility failed to ensure the safety and prevent elopement for 3 (Resident#100, Resident #101, Resident #105) of 5 residents reviewed for elopement, resulting in an Immediate Jeopardy when Resident #100 and Resident #101 left the premises alone, unbeknownst to staff, for an extended period, and were later found in the community and the likelihood for serious harm and/or injury for Resident #105. Findings include: Review of the facility Elopment Policy dated [DATE] and revised [DATE] revealed, Policy: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues addressed in their individual plan of care. Procedure: 1. Residents who have been assessed at risk for elopement/wandering shall be provided at least one of the following safety precautions by the facility: a. An adult electronic monitoring safety device will be used to notify/alert staff by sounding an alarm when the resident enters the perimeter around an alarmed door. b. Door alarms placed on facility exits. c. Keypad controlled elevators. d. Resident will be listed in the Elopement Book, which will be located at the reception desk and each nursing station. 1. As part of the facility ' s Preventative Maintenance Program, all doors and elevator keypads will be checked for proper function on a weekly basis by the Maintenance department/designee. These checks will be documented with date and time completed. 2. Residents with an adult electronic monitoring safety device will be checked every shift to ensure device is in place. 3. Adult electronic monitoring safety device will be checked weekly to ensure the device is functioning properly and is not expired. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. At no time shall a door alarm be turned off, without the continual supervision of the exit. *If the alarm must be turned off, it is the responsibility of the person disarming it to make sure it is functioning properly once the alarm is turned back on. Residents/Elopement : 1. All residents shall be reviewed for safety awareness impairment and elopement/wandering concerns upon admission, readmission, quarterly, significant change in condition and as needed. 2. Residents identified as at risk for elopement/wandering will have a plan of care implemented to address their elopement/wandering behaviors. 3. All residents who are at risk for possible elopement/wandering shall be accompanied by staff or responsible party when leaving the residents unit and/or facility grounds 5. When the door alarm sounds, staff members shall immediately respond to determine the cause of the alarm. Review of Elopement: Assessment and Safety Essentials by [NAME] Struck, RN, published [DATE], Provider Magazine revealed While wandering in a facility can present harmful situations .the opportunities for injury multiply after a resident elopes from the nursing facility. Additional risk assessment should be performed after there is any change in the resident's condition .(assessment) should include physical, psychological and historical factors .a resident's history is of paramount importance in the assessment process .factors that signal concern include .problem with adjustment to the facility .stating a desire to go home or feeling imprisoned .hovering near exits . Resident #100 Review of an Admission Record revealed Resident #100, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral infarction (stroke), peripheral vascular disease (disease causing reduced blood flow), muscle weakness, and cognitive communication deficit(difficulty communicating related to disruption in cognitive processes, such as memory, attention, or problem solving). Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] which indicated Resident #100 was moderately cognitively impaired. Section GG of the MDS revealed Resident #100 could propel his wheelchair 150 feet independently. Review of a Care Plan for Resident #100, with a reference date of [DATE], revealed focuses/goals/interventions of: 1. Focus: Resident has limited physical mobility r/t bilateral amputation of all toes. Goal: Resident will remain free of complications related to immobility, such as .skin-breakdown, fall related injury through the next review date. Interventions: .Resident is NON-WEIGHT BEARING .due to bilateral toe amputation of all toes .total mechanical lift .however resident is non-compliant . 2. Focus: Resident at risk for falls .Goal: Resident will remain free from fall related injury .Interventions: provide assistance as needed for mobility .assure utilization of appropriate devices .assistive device: wheelchair . Resident had no care plan related to elopement concerns at the time of his elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Fall Risk Assessment for Resident #100, with a reference date of [DATE] revealed the resident was at a high risk for falling. Review of a Wandering Risk Scale assessment for Resident #100, with a reference date of [DATE], revealed the assessment was deemed not applicable because Resident is ONE OF THE FOLLOWING: comatose, dependent on ADL and cannot move without assistance, and/or stuporous. As a result, Resident #100 scored 0 (low risk) for elopement. Review of a Certification of Incapacity for Resident #100, with a reference date of [DATE], revealed the resident was deemed unable to make medical decisions for himself based on a lack of awareness of risks/benefits, and an inability to develop a reasonable rationale for decisions. Review of a Nursing Progress Note for Resident #100, with a reference date of [DATE] revealed Resident oriented to his room. He states he is frustrated with the facility and feels like a prisoner. He would like to go home. Review of a Physical Therapy Progress Note for Resident #100, with a reference date of [DATE], revealed the resident was already able to transfer and walk without assistance but in doing so, was noncompliant with his weightbearing restrictions. Review of a Behavior Health Assessment for Resident #100, with a reference date of [DATE] revealed the resident was diagnosed with adjustment disorder with depressed mood on this date. Review of a Nursing Progress Note for Resident #100, with a reference date of [DATE] revealed Resident not following fluid restriction, self-transfers to bathroom to fill cup. Resident states he is leaving tomorrow. In an interview on [DATE] at 1:47pm, Certified Nursing Assistant (CNA) N reported Resident #100 expressed his desire to go home almost every day, resisted any assistance with cares, refused to follow his non-weightbearing status on his feet, and hovered by various doors frequently. In an interview on [DATE] at 9:31am, Resident #109 reported on [DATE] at approximately 8:30pm, the door alarm for the front door of the facility was sounding for nearly 20 minutes and she went to investigate the situation. Resident #109 reported she arrived at the lobby near the front door, the alarmed continued to sound and she was not able to locate any staff. Resident #109 reported she did not see anyone outside and opted to turn off the alarm herself. Resident #109 reported there was a reset button for the alarm that was easily accessible to everyone, and she pushed it to turn off the alarm. Resident #109 reported she learned later that a resident had eloped that evening. Resident #109 also reported that she and other independent residents had a code to use to exit the building without activating the alarm. Review of a Nursing Progress Note for Resident #100, with a reference date of [DATE] revealed This resident was last observed by nurse around 19:30 (7:30pm) .Resident found at 21:42 (9:42pm) at (local business 0.25 miles from facility). Resident states he wants to go home and that's why he left. (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 [DATE], at 11:41am, family member/durable power of attorney (FM) AA for Resident #100 reported Resident #100 had expressed a desire to leave the facility repeatedly since his admission and was calling anyone who'd answer the phone demanding they come pick him up. FM AA reported Resident #100 had a long history of not complying with medical recommendations and rules put in place by others. FM AA reported he was not surprised when the facility called him on [DATE] and reported Resident #100 left the building because the resident had been saying for weeks that he wanted to leave, and the facility was aware of this as well. FM AA reported he did not believe Resident #100 was safe to leave the facility alone because his mental capacity had worsened in recent months. In an interview on [DATE] at 11:26am, Nursing Home Administrator (NHA) A reported Resident #100 repeatedly expressed a desire to go home within a few days of his arrival and had been assessed as a low risk for elopement at the time of his admission but had not been reassessed until after he eloped on [DATE]. NHA A also reported the resident had a long history of noncompliance and poor decision making. NHA A confirmed at the time of his elopement, Resident #100's care plan had no interventions in place to reduce his risk of elopement, but a care plan would have been generated had he been reassessed and deemed at risk. Resident #100 no longer resided in the facility. An effort to contact Resident #100 was made on [DATE] at 11:49am. The telephone number provided had been disconnected. Resident #101 Review of an Admission Record revealed Resident #101, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia, fracture of unspecified part of right clavicle, repeated falls, and age-related osteoporosis (disease that causes bones to become weak and more likely to break). Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] which indicated Resident #101 was moderately cognitively impaired. Section GG of the MDS revealed Resident #101 required supervision and/or steadying assistance to walk 150'. Review of a Care Plan for Resident # 101, with a reference date of [DATE], revealed a focus/goal/interventions of: Resident is an elopement risk .Goal: Minimize risk of elopement .Interventions: Distract resident when increased wandering by offering pleasant diversions .encourage family visits during peak exit-seeking times . Review of a Physician's Progress Note from another facility dated [DATE], located in Resident #101's current medical record, revealed SW (social worker) working with locked unit facility for increased risk of elopement with patterns of wandering and exit seeking behaviors . Review of a Federally Mandated Visit physician note for Resident #101, with a reference date of [DATE] revealed: Patient .previously presented to (name of another skilled nursing facility) for rehab .he required further oversight due to increased risk of elopement .and exit seeking . and was transferred to this facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearstream Rehabilitation and Nursing Center	240 E North St Hastings, MI 49058

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE], at 3:02pm, Certified Nursing Assistant (CNA) C reported she regularly cared for Resident #101 and to her knowledge, he had no history of exit seeking prior to [DATE]. CNA C reported when she went to retrieve Resident #101's lunch tray from his room on [DATE] at approximately 12:30pm, she became concerned because the resident was not in his room and was not on the locked memory care in which he resided. CNA C reported a search began. CNA C reported the door alarms were not sounding at that time. CNA C reported she later cared for Resident #101 when he was returned to the unit. CNA C described Resident #101 as tired and thirsty upon his return. Review of a General Progress Note for Resident #101 with a reference date of [DATE] revealed .after lunch staff began to pick up trays .Resident (#101's) tray had not been touched .all staff began checking all rooms . staff exited building .Resident was observed standing at mail truck, a police car on scene .Resident appeared out of breath and was holding onto the mail truck . In an interview on [DATE] at 12:49pm, Postal Carrier (PC) Z reported she was driving on the facility street, going west when she saw an elderly man walking on the side of the road. PC Z reported she was concerned the man's safety because he looked lost, was dressed too warmly for the weather, the road was heavily trafficked, and she stopped to assist him. PC Z reported the man was Resident #101 and he was more than a block away from the facility. PC Z described Resident #101 as thirsty, tired, winded, and disoriented. PC Z reported Resident #101 was clothed in unseasonably warm clothes with long sleeves and a jacket. In an observation on [DATE] at 1:00pm, it was determined that the roadway on which Resident #101 was found, had a speed limit of 25mph and there was no sidewalk for pedestrians. The road surface was uneven, and the road was frequently used by vehicles as it led from a large residential area to main thoroughfare of the city. In an interview, Legal Guardian (LG) BB for Resident #101 reported the resident transferred to this facility from another facility on [DATE] after the first facility couldn't give him what needed because he was trying to leave the facility. LG BB reported the transition to a nursing facility had been very stressful and confusing for Resident #101 and she worried about his well being if he eloped since he did not know where he was and would not be able to maintain his own safety. LG BB reported Resident #101 had no family members involved in his life. In an interview on [DATE] at 8:21am, Maintenance Supervisor (MS) L reported prior to [DATE], the facility did not have a followed schedule for checking door alarms and there was a bypass button accessible to anyone in the lobby area that would shut off the alarm. MS L reported some doors in the facility had personal alarm monitors, including the exit door in the locked memory care unit but personal alarms were not used for resident's in the memory care unit. MS L reported he worked at the facility for 4 years but had no documentation of door alarm checks prior to ,d+[DATE]. Resident #105 Review of an Admission Record revealed Resident #105, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia(chronic condition that affects thinking, reasoning, and memory)major depressive disorder, and psychotic disorder (mental disorder characterized by disconnect with reality). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] which indicated Resident #105 was cognitively intact. Review of a Care Plan for Resident # 105, with a reference date of [DATE], revealed a focus/goal/interventions of: Focus: Resident is a smoker .Goal: Resident will not suffer injury from unsafe smoking practices .Interventions: Resident must have supervision with smoking . Resident #105 had no care plan related to elopement as of [DATE] at 3:08pm. Review of a Wandering Risk Scale assessment for Resident #105, with a reference date of [DATE] revealed the resident was deemed at risk for wandering/elopement on this date. In an interview on [DATE] at 1:34pm, Certified Nursing Assistant (CNA) F reported Resident #105 left the building unsupervised several times during the period of ,d+[DATE]/-[DATE]. CNA F reported the resident was supposed to be supervised any time she left the building now because she was recently deemed not her own person and was no longer safe. CNA F reported she was unsure how or when the resident left the facility, that no alarms sounded until the resident triggered the alarm while trying to re-enter the facility. In an interview on [DATE] at 9:42 am, Certified Nursing Assistant (CNA) S reported until [DATE], Resident #105 and several other used the alarm code to go outside alone and smoke. CNA S reported having the alarm code would allow residents to open exterior doors without an alarm sounding. Review of a Nursing Progress Note for Resident #105, with a reference date of [DATE] revealed: Resident went outside this am and knew the code to get out of the door. In an interview on [DATE], at 9:51am, Resident #105 reported she knew the alarm code for the exterior doors until about a week ago and stated, It was 1 2 3 4 for a long time and we would go out alone to smoke. In an interview on [DATE] at 10:41am, Social Services Coordinator (SS) GG reported at around 8:00am on this date, she heard the door alarm sounding, responded, and found Resident #105 outside alone, raking leaves. In an interview on [DATE] at 11:01am, MDS Coordinator (MDS/RN) O reported Resident #105 was deemed at risk for wandering/elopement on [DATE] and should have had a personal alarm bracelet placed at that time but did not have one until [DATE]. MDS/RN O confirmed Resident #105 went outdoors to smoke regularly. MDS/RN O also confirmed there was no record of staff checking the personal alarm to ensure it was functioning properly. MDS/RN O confirmed that Resident #105 was not safe to go outdoors alone. In an interview on [DATE] at 11:26am, Registered Nurse/Staff Development Coordinator (RN) D reported there was no physician order for the use of a personal alarm that had been placed on Resident #105 on [DATE] or to check the device daily. RN D also confirmed the resident did not have an active care plan in place for her risk of elopement until [DATE]. When further queried, RN D reported she believed she told staff to place a personal alarm on Resident #105 over the weekend after they reported the resident left to building without supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Wandering Risk Scale assessment for Resident #105, with a reference date of [DATE] revealed the resident was deemed high risk for wandering/elopement and had wandered in the past month. In an interview on [DATE] at 11:30am, Nursing Home Administrator (NHA) A confirmed that the facility's policy was for all residents who were at risk for elopement/wandering to be accompanied by staff or a responsible party when leaving the residents unit and/or facility grounds. NHA A also confirmed residents identified at risk for elopement/wandering should have a plan of care to address their safety needs. On [DATE] at 1:57 PM, Nursing Home Administrator (NHA) A was verbally notified and received written notification of the Immediate Jeopardy that began on [DATE] due to the facility's failure to prevent the elopement of Resident #100 and Resident #101 and Resident #105. A written plan for removal for the Immediate Jeopardy was received on [DATE] at and the following was verified on [DATE]: On [DATE], all licensed nurses present in the facility were re-educated on warning signs of elopement, reassessing residents to determine their risk of elopement and development of an elopement care plan and communicating new resident needs related to elopement to the interdisciplinary team. Non licensed staff were educated on resident warning signs for elopement and need to report signs to the nurse immediately. Plan put in place to educate every staff member prior to their next working shift. On [DATE], Facility confirmed all at risk residents had a care plan to address their needs related to their risk of elopement as well as a functioning personal alarm. On [DATE], Facility confirmed all door alarms and personal safety alarms were in working order and were monitored for functionality daily. On [DATE], Resident #101 was placed on 15-minute checks until a personal safety alarm was placed on him. On [DATE], Facility ensured the door codes were changed. On [DATE], Facility ensured elopement drills will be conducted on a weekly basis. On [DATE], Facility ensured signs were posted to educate visitors on the need to avoid assisting any resident through a door and to have staff escort visitors out of the building. On [DATE], Facility ensured the elopement book was reviewed and up to date. On [DATE], Facility reviewed the elopement policy and deemed it was appropriate. On [DATE], Facility ensured all windows were functioning properly. On [DATE], Facility ensured behavior tracking orders for elopement tendencies were added to all residents at risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of harm due to:1. the fact that not all facility staff have received the education and sustained compliance has not been verified by the State Agency and 2. Resident #106 had sustained harm in a fall. DPS #2: Based on observation, interview, and record review, the facility failed to minimize the risk of injury during mechanical lift transfers for 1 (Resident #106) of 3 residents reviewed for falls, with a potential to impact 19 residents who rely on the use of a mechanical lift for transfers. Findings include: Review of a (product name and brand omitted) Operating and Product Care Instructions manual, with a reference date of ,d+[DATE], pg. 4 revealed: (product name omitted) is intended to be used with (brand name omitted) slings. Only use (brand name omitted) supplied slings and stretchers that designed to be used with (product name omitted) .the expected operational life for fabric slings is approximately 2 years from the date of purchase. Review of a (Product Brand Omitted) Slings User Guide, with a reference date of ,d+[DATE], provided by the facility revealed: Operating instructions .always check that the sling attachment clips are fully in position before and during the commencement of the lifting cycle .Care for your slings .if the sling label is missing or cannot be read the sling should also be withdrawn from use. Review of an Admission Record revealed Resident #106, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral infarction (stroke), major depressive disorder, unspecified dementia, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of [DATE] revealed Resident #106 could not complete a Brief Interview for Mental Status due to her level of dementia. Section GG of the MDS revealed Resident #106 required maximal assistance (helper does more than half the effort) to transfer from bed to wheelchair. Section K of the MDS revealed Resident #106 weighed 126 pounds. Review of a Care Plan for Resident # 106, with a reference date of [DATE], revealed a focus/goal/interventions of: Resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) end stage dementia. Goal: Resident will participate in ADL tasks with therapy services as ordered .Interventions: TRANSFER: TOTAL Mechanical lift-yellow sling 2 person assist with all transfers .([DATE]). Review of an Investigation Summary with a reference date of [DATE] revealed: (Resident #106) was being transferred via lift following care plan with proper sling .the lift sling came detached and resident fell to floor . (Resident #106) sent to hospital .returned .with stitches to the laceration to the back of her head and a hematoma. Conclusion: it was concluded that due to size of resident (weight 125#) the connectors did not seat completely causing them to disconnect from the securement pegs .Pt (patient) will be a two person assist with all transfers needs going forward. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an Emergency Department Progress Note for Resident #106, with a reference date of [DATE] revealed: Diagnosis: injury of the head .patient .presents after falling from (name of device) lift, has a cervical collar on .spoke with her durable power of attorney and he does not want any imaging done .the patient did have significant bleeding from her head wound .I did place several deep and wide sutures pulled tight around this area .ultimately 4 sutures placed in total . In an interview on [DATE], at 9:33am, Agency Certified Nursing Assistant (CNA) X reported on [DATE] as she was transferring Resident #106 from her bed to the wheelchair, 2 of the 4 straps (both on the resident's right side) became unclipped from the fastening pins of the device, which caused Resident #106 to fall to the floor. CNA X reported she had been trained to use that type of lift at another facility. CNA X reported she attached the sling clips while Resident #106 laid in bed, assisted the resident into a seated position and then initiated lifting the resident with the device. CNA X reported Resident #106 fell as the device was moving her off the bed. In an interview on [DATE] at 1:39pm, Certified Nursing Assistant (CNA) G reported she used the mechanical lift to transfer residents several times a day and had experienced the sling clips popping off the placement pins at times. As a result, CNA G reported she always checked the placement of the clips as the resident began to be lifted from a surface. In an interview on [DATE] at 2:14pm, Certified Nursing Assistant (CNA) G reported she transferred Resident #106 regularly using the mechanical lift and had learned it was important to use the device slowly and double check the clips to ensure they stayed in place. In an interview on [DATE] at 2:44pm, Physical Therapist (DPT) Y, movement specialist consultant from the mechanical lift company, reported a facility should have their lift slings evaluated every ,d+[DATE] months by a qualified personnel. DPT Y reported it was a safety concern to use a sling that did not have a manufacturer's tag because the age of the sling could not be determined. DPT Y reported the slings were only designed to be safely used for approximately 2 years before the wear experienced during normal use would make them no longer effective. DPT Y reported the composite material clips may experience slight changes in opening on the clip that would not appear significant but could reduce their effectiveness with remaining snapped on the lift pins. DPT Y reported facility's must schedule preventative maintenance appointments specifically for the slings because the facility's entire sling inventory would not be inspected when the company provide maintenance for the mechanical lift machines. DPT Y reported based on Resident #106's weight of 126 pounds, the sling used to transfer her was the correct size. In an interview on [DATE] at 2:56pm, Nursing Home Administrator (NHA) A reported the facility had not done routine inspections of the mechanical lift slings until a new process was implemented on [DATE]. NHA A reported the facility planned to have laundry staff inspect the slings for holes and fraying in the soft materials. When further queried, NHA A reported the facility did not reach out to the manufacturer regarding Resident #106's fall during the use of their mechanical lift and did not seek guidance regarding sling maintenance. NHA A did not voice a plan to have the slings professionally inspected. NHA A provided the sling that was used for the transfer during Resident #106's fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on [DATE] at 3:05pm, the sling NHA A provided, it was noted that a manufacturer's tag was not present. The sling was a lavender color with green trim and had four black composite material clips. The edges of the opening on the clips appeared somewhat worn. When the sling clips were placed on the pins of the mechanical lift, they unsnapped from the pins when light pressure was applied. During an interview on [DATE] at 4:09pm, Director of Nursing (DON) B examined the sling that was used for the transfer during which Resident #106 fell . DON B confirmed the brand and age of the sling could not be confirmed because the sling did not have a manufacturer's tag. The facility was not able to provide an invoice to determine the age of the sling used for Resident #106. During an observation on [DATE] at 9:03am, Certified Nursing Assistant (CNA) J was alone with Resident #106, in the resident's room. Resident #106 sat in her wheelchair with the mechanical lift sling under here. CNA J reported she was going to transfer Resident #106 to bed. CNA J fastened the sling clips to the securement pins on the mechanical lift and pushed the controller that activated the lift. As Resident #106 began to rise from her chair, the surveyor asked the CNA to stop and return the resident to her wheelchair. CNA J was asked to review Resident #106's plan of care regarding her needs for transfers. Upon reviewing the plan of care, CNA J confirmed that Resident #106 needed 2 staff members present for transfers. When further queried about why she initiated a transfer for Resident #106 with only one staff member, CNA J reported she was not aware the resident needed 2 staff members present for transfers.