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	02/26/2026

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 - Minimal harm or potential for 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** This citation pertains to intake #2674240Based on observation, interview and record review, the facility failed to protect the residents' right to be free from resident-to-resident physical abuse for 2 (Resident #103 and Resident #104) of 4 residents reviewed for abuse resulting in Resident #104 grabbing Resident #103 by the arm, and Resident #103 slapping Resident #104 in the face.Findings include:Resident #103Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills) and generalized anxiety disorder (mental health condition characterized by persistent feelings of worry and restlessness).Review of a Minimum Data Set (MDS) assessment for Resident #103 with a reference date of 11/29/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 0/15, which indicated the resident was severely cognitively impaired.Review of a Care Plan for Resident #103 with reference date of 6/2/25 revealed the following focus/goal/interventions Focus: (Resident #103) spends time walking around in the unit picking up sensory items.Goal: Resident will participate in activities of choice.Interventions.staff will.offer cues and prompts as needed. Resident #103 did not have a care plan related to picking up other residents' belongings.Review of an Incident Report with a reference date of 11/13/25, authored by Nursing Home Administrator (NHA) A revealed Perpetrator Name: Resident #103, name omitted. Witnesses: FM EE, name omitted. Incident summary: (Resident #103) was walking by (Resident #104) and picked (Resident #104's) gloves up. Resident #103 walked away.Resident #104 followed her and took ahold of her (Resident #103) arm. (Resident #103) made open hand contact with Resident #104's face.In an interview on 2/26/26 at 3:47pm, Resident #103's Durable Power of Attorney (DPOA) DD reported the facility had contacted her on 11/13/25 and reported she hit another resident in the face after the resident grabbed Resident #103 by the arm. DPOA DD reported Resident #103 could no longer successfully express her emotions, but in the past, she would have been upset if someone was physically aggressive toward her and would have reacted. DPOA DD reported Resident #103 walked around the unit and picked up various items frequently.During an observation on 2/26/26 at 1:30pm Resident #103 was standing in the dining area. Approximately 15 other residents were seated at the tables, awaiting lunch. Resident #103 wandered around the room, then walked down the hall and entered another resident's room.In an interview on 2/26/26 at 1:35pm, Licensed Practical Nurse (LPN) E reported Resident ##103 walked around and explored her environment by picking items up frequently but did not have the capacity to consider ownership of the items she was handling. Resident #104Review of an admission Record revealed Resident # 104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (a decline in mental ability-specifically memory, thinking and reasoning), major depressive disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and loss of interests) and suicidal (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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ideation (thoughts or preoccupations with ending one's own life).Review of a Minimum Data Set (MDS) assessment for Resident #104 with a reference date of 11/14/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12/15, which indicated the resident was moderately cognitively impaired.Review of a Care Plan for Resident #104 with a reference date of 5/29/25 revealed the following focus/goal/interventions: Focus: (Resident #104) is at risk for a psychosocial well-being concern r/t (related to) Suicidal Ideation.history of attempting suicide. Goal: The resident will have no indications of psychosocial well-being problem. Interventions.when conflict arises, remove residents to calm safe environment. Resident #104 had no care plan related to her frustration with peers.Review of a Progress Note for Resident #104 with a reference date of 11/13/25 revealed This writer spoke with (Resident #104) about a disagreement she had with another resident about her gloves. I asked if she was still upset that.she stated that she was upset at first.Review of a Psychiatry Initial Evaluation for Resident #104 with a reference date of 2/11/26 revealed .Social/Psychiatric.She argues with another resident at facility.current symptoms include anxiety, depression, irritability.In an interview on 2/26/26 at 3:24pm, Resident #104 was unable to recall the altercation that took place on 11/13/25.In an interview on 2/26/26 at 4:02pm, Certified Nursing Assistant (CNA) Q reported she did not witness the altercation between Resident #103 and Resident #104, but she did know that Resident #104 felt frustrated by the actions of other residents and would respond by yelling at them.In an interview on 2/26/26 at 2:27pm, Family Member (FM) BB reported on 11/13/25 at approximately 2:30pm, in the dining area of the memory care unit, she witnessed a physical altercation, during which Resident #104 grabbed Resident #103 by the arm and Resident #103 slapped Resident #104 in the face. FM BB reported Resident #103 walked past Resident #104 and picked up a pair of gloves that were next to Resident #104. FM BB reported as Resident #103 carried the gloves and began walking down the hall, Resident #104 went after her (Resident #103), forcefully grabbed Resident #103's arm and pulled back in a manner that caused Resident #103 to turn around. Resident #103 then slapped Resident #104 on the side of her face. FM BB reported Resident #104 appeared angered after being struck in the face and stated, She slapped me in the face!. Using the reasonable person concept: (a legal concept that describes what a fictitious person of ordinary [NAME] would do under the circumstances), 1. Resident #103 would not want to be grabbed forcefully by the arm and would experience frustration and anxiety because of that act. 2. Resident #104 would not want to be slapped in the face as she tried to retrieve her own belongings and would experience pain, frustration, anger and anxiety because of this act. Review of a Resident Rights, Abuse and Neglect policy with a reference date of 6/28/25 revealed POLICY: It is the policy of the facility to provide professional care.in an environment that is free from any type of abuse.Types of Abuse and Examples: Physical: Physical abuse includes but not limited to infection of injury.Example: hitting, slapping.grabbing.