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	05/05/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review the facility failed to provide food at a palatable temperature for 1 of 1 resident (R33), resulting in the potential for decreased food consumption for all residents who receive food from the kitchen and nutritional decline.Findings Include: Resident #33 During an interview on 5/3/2026 at 10:08 AM, Resident #33 reported ongoing concerns with cold food. Resident #33 reported she felt that the food was a bit warmer when served in the dining room, but when she ate meals in her room, the food was always cold. Resident #33 reported she had spoken with multiple facility staff members on numerous occasions about her concerns with food, but they were still serving cold food often. In a follow up interview on 5/4/2026 at 1:11 PM, Resident #33 was sitting in her chair in the dining room. Resident #33 reported she had just eaten her lunch, which was served cold, even though she had received her meal in the dining room. Resident #33 voiced frustration about being served cold food frequently. In a follow up interview on 5/5/2026 at 12:37 PM, Resident #33 was sitting up in her bed eating her lunch. Resident #33 voiced frustration that her meal was served cold. Resident #33 reported she felt like the staff tried to get meal trays delivered to rooms as fast as they could, but the food temperature was still cold by the time the meal was served to her. Resident #33 reported that her pork chop and potatoes at this meal were not warm to her mouth. In an observation on 5/5/26 at 12:46 PM, meal trays were delivered to the B hall. This writer intercepted the last tray available on the cart as a sample tray at 12:50 PM, the porkchop was 126.5 and the roasted potatoes were 117 degrees. Review of the facility's Proper food portions and plating policy dated 2/26/25 revealed, POLICY: It is the policy of this facility to ensure that all meals are portioned appropriately . providing adequate food quantity while maintaining palatability and visual appeal . On 5/4/26 at 11:49 AM, an interview with Dietary Director (DD) W found that hot food on the steam table should stay hot through service. When asked if temperatures of the product were taken before service, [NAME] JJ stated that they got in a hurry today and preservice temperatures were not taken of items on the steam table. At this time, the surveyor took temperatures of the asparagus and the chicken breasts and found the asparagus around 165F and the chicken breast ranging from 110F to 138F. Staff continued plating meals knowing this information. On 5/4/26 at 12:30 PM, a test tray was plated for the D hall unit and was placed first on the D hall (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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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cart with 11 trays that followed for the residents of D hall. On 5/4/26 at 12:46 PM, the meal cart arrived in D hall and two staff started delivering trays. On 5/4/26 at 12:56 PM, all meals on the D hall were delivered and the test tray was back in the conference room with the following temperatures noted: Chicken Breast was 96F, [NAME] was 102F, and the asparagus was 101F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.Findings Include:On 5/4/26 at starting at 8:05 AM, a follow-up tour of the kitchen with Dietary Director (DD) W occurred.On 5/4/26 at 8:26 AM, observation of the shelf above the hand sink found a spray bottle with a yellow solution that didn't have a common name for labeling.According to the 2022 FDA Food Code section 7-102.11 Common Name. Working containers used for storing POISONOUS OR TOXIC MATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material.On 5/4/26 at 8:28 AM, observation of the three-door cooler labeled #1, found a cooked ham and a bag of cooked brats sitting on two log packages of raw ground beef in the bottom right of the cooler. When asked about proper storage in the cooler, DD W stated the ready to eat food, like the cooked ham and brats, should not be stored with raw product and moved the ham and brats to a higher shelf.On 5/4/26 at 3:22 PM, observation of the three-door cooler labeled #1 found that a box of raw shaved steak was sitting on top of a box of cooked roasts on the bottom left of the cooler. Further review of the cooler found staff had rearranged the right side so that a tray of drinks could be added to the reach in cooler, in order to do so, the cooked ham and package of cooked brats was moved back to the bottom shelf and was found laying on the log packages of raw ground beef. At this time, an interview with DD W found that cold hold storage can get tough sometimes with limited space and large deliveries, but we should not store items like this.According to the 2022 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below or when combined as ingredients, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables, P (b) Cooked READY-TO-EAT FOOD, P and (c) Fruits and vegetables before they are washed; P.On 5/4/26 at 8:41 AM, Observation of the preparation table spice rack found an open container of lemon juice sitting at room temperature. A review of the container found that it requires refrigeration after opening.According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above,.or (2) At 5C (41F) or less.On 5/4/26 at 8:42 AM, Observation of the underside of the preparation cook line found five large metal sheet pans that were stacked and stored wet with moisture on the surfaces between the pans.According to the 2022 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD.On 5/4/26 at 9:33 AM, observation of the ice machine holder in the dining room found that it didn't have a way to properly drain and the ice scoop was sitting in the holder with roughly one inch of stagnant water sitting in the bottom of the scoop holder. When shown to DD W, she stated it gets washed regularly, but it should have a way to drain the water.According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted.On 5/4/26 starting at 11:45 AM, observation of lunch service observed staff, who plated food from the steam table, lay the handles of their tongs or mechanical scoop into the food product while plating meals. The mechanical scoop was observed laying in the container of rice three times while plating. The tong handles were observed laying in the container of chicken breast for the second half of service while staff used their gloved hands to grab the chicken.According to the 2022 FDA Food Code section 3-304.12 In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the FOOD with their handles above the top of the FOOD and the container.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure updated and accurate advanced directive information was in place for 2 (Resident #10 and Resident #5) of 18 residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility, or other healthcare providers. Findings include:Resident #10 Review of an admission Record revealed Resident #10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain) and major depressive disorder (condition characterized by persistent low mood, loss of interests in activities and low energy lasting at least 2 weeks). Review of a Minimum Data Set (MDS) assessment for Resident 10 with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment score of 9/15, which indicated the resident was moderately cognitively impaired. Review of Resident #10's Banner (Top portion of electronic medical record (EMR) that staff use to quickly identify pertinent resident information such as code status) revealed, Full Code which indicated that all possible life-saving measures will be used to save Resident #10's life. This included cardiopulmonary resuscitation (CPR) and any other medical interventions deemed necessary by physicians. Review of Advanced Directives for Resident #10, signed by a patient advocate on [DATE] revealed I fully understand the impact and potential consequences of these choices and wish to emphasize my desire to have the procedure performed or withheld, as indicated in the chart below.Cardiopulmonary Resuscitation (CPR), No. Review of Physician Orders for Resident #10 revealed Full code, status of order: active, start date [DATE]. In an interview on [DATE] at 11:51M, SW H reported although Resident #10's patient advocate signed a Do Not Resuscitate Advanced Directive on [DATE], the facility did not feel it could honor the direction of the form because the patient advocate (Resident #10's son) did not have guardianship over her at that time. SW H confirmed Resident #10's son was later granted temporary guardianship, but the facility had not pursued getting an updated Advanced Directive form for Resident #10. In an interview, Registered Nurse (RN) K reported if a resident's heart stopped beating, she would look in the resident's banner within the electronic medical record to determine if the resident wanted CPR. Resident #5 Review of an admission Record revealed Resident #5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression and visual hallucinations. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Banner (Top portion of electronic medical record (EMR) that staff use to quickly identify pertinent resident information such as code status) revealed, Full Code which indicated that all possible life-saving measures will be used to save Resident #5's life. This included cardiopulmonary resuscitation (CPR) and any other medical interventions deemed necessary by physicians. Review of Resident #5's Advance Directive form dated [DATE] revealed, . I (Resident #5), being sound mind freely acknowledge that if I am unconscious or terminally ill, and unable to participate in my own medical decisions, I expressly and ambiguously wish the following personal choices for my care to be honored by all who read this document. I fully understand the impact and potential consequences of these choices and wish to emphasize my desire to have the procedures performed or withheld, as indicated in the chart below: CPR: This was marked as unsure . Noted that the form was signed by Resident #5's guardian on [DATE]. Review of Resident #5's Do-Not-Resuscitate (DNR) Order Guardian Consent revealed, . Guardian Consent: I authorize that in the event the ward's (Resident #5) heart and breathing should stop; no person shall attempt to resuscitate the ward. I fully understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law. Noted that the form was signed by Resident #5's guardian on [DATE], but the form was not signed by two witnesses or a physician. During an interview on [DATE] at 3:48 PM, Social Worker (SW) H reported she thought that Resident #5 was listed as a full code in his EMR because Resident #5's guardian had indicated that she was unsure about CPR on Resident #5's Advance Directive form. When this writer queried about the DNR order that was signed by Resident #5's guardian, SW H reported she was unaware that Resident #5 had an incomplete DNR form scanned into his EMR. SW H reported the facility reviewed resident advance directives quarterly at resident care conferences. SW H reported Resident #5's most recent care conference was on [DATE]. SW H reviewed Resident #5's Care Conference notes from [DATE] and confirmed that the facility staff had not reviewed Resident #5's Code status/Advance Directives at this conference. On [DATE] at 4:00 PM, Nursing Home Administrator (NHA) A sent this writer via email the facility's Advance Directive Action Plan dated [DATE] revealed, Assessment: The facility identified that updated guardianship paperwork was not being obtained, and code statuses were still being signed by the guardian on file. Action Steps: SW completed a guardianship audit to identify who we needed to request documents for . Status Report: Completed on [DATE]. SW reached out to guardians to request updated documents and verify code status signatures were appropriate . Status Report: Completed on [DATE]. In a follow up interview on [DATE] at 8:26 AM, SW H reported she had reached out to Resident #5's guardian on [DATE] and had a lengthy discussion on the discrepancy with Resident #5's code status. SW H reported that Resident #5's guardian had told her that she felt that she did not think that Resident #5 would want to live in his current state, and she felt that he would want to be DNR. This writer attempted to contact Resident #5's guardian on [DATE] at 3:50 PM. Attempts to contact Resident #5's guardian was unsuccessful by the time of survey exit. Review of the facility's Advance Directive policy dated [DATE] revealed, Policy: It is the policy of this facility to:1. Provide written information to residents at time of admission regarding a.Their right (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	under State Law to accept or refuse medical treatment and the right to formulate Advance Directives such as the Natural Death Act, Durable Power of Attorney for Health Care Decision, or living will, in accordance with the Resident Self Determination Act. The facility's policy to implement such decisions and directives .Procedure: 1. Designated staff will review and explain the specified State Law addressing Advance Directives options and Life Sustaining Treatment with the resident and/or representative. 2. Staff will provide the resident and/or representative with information regarding advance care planning which will address types of Advance Directives, treatment options and refusal of treatment. 3. Information will be reviewed and the resident and/or representative will be asked to sign and acknowledge that they have received the information on Advance Care Planning. 4. An Advance Directive form (as provided by the healthcare facility) shall be completed with resident and/or legal representative to verify treatment options as well as code status .6. The resident's Advance Directive choices/options shall be reviewed during the re-assessment and quarterly care planning process .

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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** Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 (Resident #67) of 4 residents reviewed for abuse resulting in Resident #67 being inappropriately touched by Resident #43. Findings include: Resident #67Review of an admission Record revealed Resident #67 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #67, with a reference date of 2/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident # 67 was cognitively intact. Review of Resident #67's Progress Note dated 12/10/25 revealed, Writer was walking to the top of the hall near the nurse's station and overheard (Resident #67) yelling loudly that (Resident #43) had grabbed her butt. They were both separated .Review of Resident #67's Progress Note dated 12/11/25 and documented by SW H revealed, This writer spoke privately with (Resident #67) in my office. She said she was very upset when touched inappropriately, but is feeling calm now . (Resident #67) has a plan to move rooms . She says moving rooms will increase her feeling of safety .Resident #43 Review of an admission Record revealed Resident #43 was originally admitted to the facility on [DATE] with pertinent diagnoses which included bipolar disorder (mental health condition that causes severe mood swings) and other sexual disorder (used to classify other sexual disorders that involve atypical patterns of sexual behavior or development not covered by more specific categories.)Review of a Minimum Data Set (MDS) assessment for Resident #43, with a reference date of 3/12/26 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident # 43 was moderately cognitively impaired. Review of Resident #43's Care Plan revealed, Focus: (Resident #43) has a behavior concern r/t (related to) Sexual Disorder. (Resident #43) has a history of inappropriate touching of other residents and staff, typically female and history of inappropriate social behaviors in the past. Date Initiated: 10/01/2024. Interventions: (Resident #43) will be assisted by staff last into meals/activities and will seat (sic) at an area with males only. Last in the dining area and first out of meals and activities. Date Initiated: 10/17/2024 .Review of Resident #43's Progress Note dated 12/10/25 and documented by Licensed Practical Nurse (LPN) J revealed, This writer was walking to the top of the hall near the nurse's station and heard (Resident #67) yelling that he (Resident #43) grabbed her butt .Review of Resident #43's Progress Note dated 12/11/25 and documented by SW H revealed, This writer spoke privately with (Resident #43) in my office. (Resident #43) stated that he is aware that he touched a woman inappropriately in the facility . (Resident #43) has a history of this behavior. He showed remorse and stated he knows it's not right . Review of Resident #43's Progress Note dated 12/15/25 and documented by SW H revealed, This writer spoke privately with (Resident #43) in my office This writer asked him how his safety plan was going, to keep his hands to himself. (Resident #43) asked How did you know about that? . (resident #43) was smiling and seemed content .Review of the facility's Facility Reported Investigation (FRI) dated 12/15/25 revealed, Incident Summary: Resident #67 was standing in the common area, speaking to Certified Nursing Assistant (CNA) O. Resident #43 was propelling in his wheelchair behind Resident #67 when he reached out, making contact with her buttocks. The CNA (CNA O) separated residents immediately . Resident follow up: The police showed up to the facility on [DATE] at 10:30 AM. The officer followed up with (Resident #43), according to the officer, (Resident #43) was unable to recall the situation that had occurred on the evening of 12/10/25 . Social Services followed up with (Resident #43) later in the morning, and he was able to recall being inappropriate with a female resident. (Resident #43) was remorseful, began crying and stated he knows it's not right. On 12/12/25, when Social Services followed up with Resident #43, he could not recall the occurrence . Social Services followed up with (Resident #67). (Resident #67) said she was upset that the occurrence happened, but is feeling calm (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	now . The Administrator (NHA) A followed up with this resident as well, (Resident #67) expressed that she understands that (Resident #43) has cognitive complexities and she is not afraid of him. (Resident #67) agreed that she would stay away from (Resident #43) and requested to be moved to a different unit .Conclusion: Based on the findings of the investigation, review of the clinical record, and interviews with staff members and residents, a decisive conclusion was made that the occurrence could not be verified as abuse or neglect . During an interview on 5/5/2026 at 8:11 AM, Resident #67 reported she was walking out of the dining room after dinner on 12/10/25 and she had stopped to chat with CNA O. Resident #67 reported that Resident #43 had followed behind her from the dining room to the nurse's station where he approached her and grabbed her butt. Resident #67 reported that she was very pissed and was so close to hitting Resident #43 because she was tired of him going after women in the facility. Resident #67 reported that CNA O immediately intervened and told Resident #43 not to touch women, like they always tell him, but he doesn't care. Resident #67 reported that she was worried about being on the same hall as Resident #43, so she was willing to move rooms to stay away from him. Resident #67 reported that she felt like the facility responded appropriately after the incident occurred, but she wished that they were able to keep a better eye on Resident #43 because those kinds of things should never happen. During an interview on 5/4/2026 at 3:27 PM, Licensed Practical Nurse (LPN) J reported she was the nurse caring for Resident #43 when he approached Resident #67 and grabbed her butt. LPN J reported she did not observe Resident #43 grab Resident #67, but she had heard Resident #67, so she went to the nurse's station where CNA O had told her that Resident #43 had exited the dining room and grabbed Resident #67's butt. LPN J reported Resident #43 had a history of touching females inappropriately and staff needed to monitor him around female residents at all times. During an interview on 5/4/2026 at 2:08 PM, SW H reported she had been made aware on 12/11/25 that Resident #43 had approached Resident #67 and grabbed her butt. SW H reported Resident #43's brother had reported to her that Resident #43 had a history of sexually inappropriate behavior towards women. SW H reported that she felt that Resident #43's actions were not intentional, but that he was just reaching in general. SW H then confirmed that Resident #43 had reported to her that he knew what he had done was not right. This writer attempted to reach CNA O via telephone on 5/05/2026 at 11:32 AM. This writer was unsuccessful in speaking to CNA O prior to survey exit.During an interview on 5/5/2026 at 11:47 AM, NHA A reported he was aware that Resident #43 had a history of inappropriately touching females. NHA A confirmed that the incident had occurred in a common area as Resident #43 was exiting the dining room without staff assistance. When this writer queried about Resident #67's care plan intervention for staff to assisted Resident #43 last into meals/activities and will keep Resident #43 at an area with males only. Last in the dining area and first out of meals and activities, NHA A reported he was not aware of that intervention, and he had missed that staff had not escorted Resident #43 out of the dining area. NHA A reported that he felt that the incident between Resident #43 and Resident #67 did not rise to level of abuse because Resident #67 had reported to him that she understood that Resident #43 had cognitive complexities and she was not offended or that Resident #43 had meant to harm her. NHA A confirmed that Resident #67 had voiced frustration and requested to be moved to another hall to get away from Resident #43. Review of the facility's Abuse policy dated 6/28/25 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, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. This includes but is not limited to freedom from any physical or chemical restraint not required to treat the resident's medical symptoms . Types of sexual abuse: Sexual is defined as non-consensual sexual contact of any type with a resident. Generally, sexual contact is nonconsensual if the resident either: appears to want the contact to occur but lacks the cognitive ability to consent; or does not want the contact to occur . Sexual abuse includes, but is not limited to unwanted intimate touching of any kind especially of breasts or perineal area; all types of sexual assault or battery, such as rape, sodomy, and coerced nudity; forced observation of masturbation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or pornography; and taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that written bed hold notice was provided to 1 (Resident #95) of 3 residents reviewed for transfer and discharge from the facility.Findings include:Resident #95 Review of an admission Record revealed Resident #95 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: malignant neoplasm (cancer that has spread to other parts of the body), weakness, and hypertension (high blood pressure). Review of a Minimum Data Set (MDS) assessment for Resident #95, with a reference date of 2/9/26 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #95 was mildly cognitively impaired.Review of Progress Note for Resident #95 dated 2/11/26 at 14:35 (2:35 PM) revealed .they recommended transfer to ED (emergency department) for eval (evaluation).Resident notified.(Name Omitted) provider notified and ordered to transfer.Review of Progress Note for Resident #95 dated 2/11/26 at 15:14 (3:14 PM) revealed Resident transferred to ED at this time vial ambulance on a stretcher.Review of Resident #95's medical record revealed no noted bed hold policy form and/or documentation that a bed hold was provided to Resident #95 prior to her transfer to the ED on 2/11/26.In an electronic communication (E-mail) on 5/4/26 at 3:17 PM, Nursing Home Administrator (NHA) A reported he was unable to provide a written bed hold policy that was provided to Resident #95 before her transfer on 2/11/26.In an interview on 5/5/26 at 1:18 PM, Agency Licensed Practical Nurse (LPN) M reported there was a packet of paperwork that needed to be set with a resident when they transferred to the hospital, but she was unsure what forms were in the packet.In an interview on 5/5/26 at 1:18 PM, LPN F reported there was a packet that went with a resident who was transferred to the hospital and sometimes that packet was forgotten.In an interview on 5/5/26 at 1:30 PM, LPN F provided a document titled Discharge Checklist and reported the checklist should be used when a resident needed to be transferred to the hospital. LPN F reviewed the list with this surveyor and confirmed that a written bed hold needed to be provided to a resident prior to transfer. Review of Discharge Checklist with an effective date of 11/30/20 revealed .Discharge to hospital: Bed hold policy for hospital transfer or therapeutic leave.provide copy to patient and/or patient representative.Review of facility policy Bed Hold Policy revealed .Facility must provide a copy of this policy to the resident and an immediate family member or legal representative before and when a resident is transferred for hospitalization or therapeutic leave.In an interview on 5/5/26 at 10:25 AM, Interim Director of Nursing (DON) B reported bed holds not being provide to the residents was a problem. Interim-DON B reported the bed hold notice was in the transfer packets, but the nurses were not sending the packets with the residents at transfer.In an interview on 5/5/26 at 10:27 AM, NHA A reported the business office staff position was vacant, and he recently discovered the former business office staff was not completing the follow up with bed hold policy with residents and/or resident representatives. NHA A reported there was no staff follow up for bed hold notices with resident's who transferred out of the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise a comprehensive, individualized plan of care after a resident-to-resident abuse incident for 1 (Resident #43) of 18 residents reviewed for care plans, resulting in the potential for unmet care needs and impaired physical, mental, and psychosocial well-being. Findings include:Resident #43 Review of an admission Record revealed Resident #43 was originally admitted to the facility on [DATE] with pertinent diagnoses which included bipolar disorder (mental health condition that causes severe mood swings) and other sexual disorder (used to classify other sexual disorders that involve atypical patterns of sexual behavior or development not covered by more specific categories.)Review of the facility's Facility Reported Investigation (FRI) dated 12/15/25 revealed, Incident Summary: Resident #67 was standing in the common area, speaking to Certified Nursing Assistant (CNA) O. Resident #43 was propelling in his wheelchair behind Resident #67 when he reached out, making contact with her buttocks. The CNA (CNA O) separated residents immediately . Resident follow up: The police showed up to the facility on [DATE] at 10:30 AM. The officer followed up with (Resident #43), according to the officer, (Resident #43) was unable to recall the situation that had occurred on the evening of 12/10/25 . Social Services followed up with (Resident #43) later in the morning, and he was able to recall being inappropriate with a female resident. (Resident #43) was remorseful, began crying and stated he knows it's not right. On 12/12/25, when Social Services followed up with Resident #43, he could not recall the occurrence . Social Services followed up with (Resident #67). (Resident #67) said she was upset that the occurrence happened, but is feeling calm now . The Administrator (NHA) A followed up with this resident as well, (Resident #67) expressed that she understands that (Resident #43) has cognitive complexities and she is not afraid of him. (Resident #67) agreed that she would stay away from (Resident #43) and requested to be moved to a different unit .Conclusion: Based on the findings of the investigation, review of the clinical record, and interviews with staff members and residents, a decisive conclusion was made that the occurrence could not be verified as abuse or neglect .Review of Resident #43's Care Plan revealed, Focus: (Resident #43) has a behavior concern r/t (related to) Sexual Disorder. (Resident #43) has a history of inappropriate touching of other residents and staff, typically female and history of inappropriate social behaviors in the past. Date Initiated: 10/01/2024. Interventions: (Resident #43) received psychiatric services from (local psych services provider). Date initiated: 12/22/25. (Noted that Resident #43 was already followed by psych services, and this was not a new intervention.) (Resident #43) will be assisted by staff last into meals/activities and will seat (sic) at an area with males only. Last in the dining area and first out of meals and activities, Staff will re-direct resident away from female residents when in common areas, BEHAVIORS: Inappropriate and unwanted touching of other residents, especially female residents. Report and document per facility protocol. CNAs to do a STOP & WATCH ALERT in POC (plan of care) if inappropriate behavior is observed, explain all procedures to the resident before starting and allow the resident time to adjust before proceeding, intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, provide resident opportunity for positive interaction and/or attention, i.e.; engage in conversation during care, address by name when passing by, etc., Praise any indication of resident's progress/improvement in behavior, Assist (Resident #43) to develop more appropriate methods of coping and interacting, Encourage the resident to express feelings appropriately, Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Follow up as indicated, Discuss with medical provider, resident &/or family, i.e. ongoing need for use of medication. Review behaviors/interventions and alternative therapies attempted and their effectiveness as per facility policy, and consult with pharmacy and medical provider to consider dosage reduction when (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinically appropriate per facility protocol. Date initiated: 10/1/24. Noted no new interventions were added after Resident #43's incident on 12/10/25. During an interview on 5/4/2026 at 2:08 PM, SW H reported she had been made aware on 12/11/25 that Resident #43 had approached Resident #67 and grabbed her butt. SW H reported Resident #43's brother had reported to her that Resident #43 had a history of sexually inappropriate behavior towards women. SW H was unable to report what new interventions had been placed in Resident #43's care plan to address Resident #43's sexually inappropriate behavior, and alternative ways to attempt to mitigate further behaviors from occurring. During an interview on 5/5/2026 at 11:47 AM, NHA A reported he was aware that Resident #43 had a history of inappropriately touching females. NHA A reported he had conducted the investigation after the resident-to-resident incident. NHA A was unable to report what interventions the facility had initiated after the incident to mitigate further behaviors from occurring with Resident #43. NHA A reviewed Resident #43's care plan with this writer and confirmed that the facility had missed updating Resident #43's care plan interventions after the resident-to-resident incident on 12/10/25. Review of the facility's Care Planning policy dated 1/15/20 revealed, Policy: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. Procedure: .8. The Care Plan will be reviewed and revised by the IDT after each assessment and as the resident's care needs change .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement pressure ulcer prevention interventions, consistent with professional standards of practice for 1 (Resident #42) of 1 resident reviewed for pressure ulcer prevention, resulting in the potential for the development of an avoidable pressure ulcer.Findings include:Resident #42Review of an admission Record revealed Resident #42 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (a syndrome characterized by a progressive, irreversible decline in memory, thinking, behavior, and the ability to perform daily tasks), and moderate protein-calorie malnutrition (deficiency of proteins, calories and micronutrients absorption causing loss of muscle and body fat). Review of a Minimum Data Set (MDS) assessment for Resident #42 with a reference date of 2/11/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 0/15, which indicated the resident was severely cognitively impaired. Section GG revealed Resident #42 was dependent (helper does all the effort) for rolling in bed, transferring to a chair/bed. Section M of the MDS revealed Resident #42 was at risk for developing pressure ulcers.Review of a Care Plan for Resident #42 with a reference date of 12/9/25 revealed the following focus/goal/interventions: (Resident #42) is at risk for potential impairment of skin integrity.Goal: (Resident #42) will maintain intact skin.Interventions.elbow pads when up in (name of specialty wheelchair brand) chair, can remove when in bed.During an observation on 5/3/26 at 10:06am, Resident #42 was up in his specialty wheelchair in the common area of the memory care unit. Both elbows were resting directly on the armrest of the wheelchair, with no elbow pads in place.During an observation on 5/3/26 at 10:09am, a mint green elbow pad was noted on Resident #42's nightstand.During an observation on 5/4/26 at 12:51pm, Resident #42 was up in his specialty chair in the common area of the memory care unit. Resident #42 was wearing an elbow pad on his right elbow. The skin on Resident #42's left elbow was gathered in several folds as it rested directly on the armrest of the wheelchair. Resident #42's left forearm rested on his chest, making the skin on his elbow easily visible.During an interview on 5/5/26 at 12:12pm, hospice certified nursing assistant (CNA) HH reported he gave Resident #42 a shower this morning, but he was not sure if Resident #42 was wearing his elbow pads at this time.During an observation and interview on 5/5/26 at 12:15pm, Resident #42 sat in his specialty wheelchair, wearing a long sleeve shirt, with both elbows resting on the armrest of the wheelchair. Registered Nurse (RN) K gently touched Resident #42's elbows and confirmed the resident was not wearing elbow pads on either arm. When queried, RN K reported she had looked all over the building and could not find any elbow pads for Resident #42 this morning. RN K confirmed per physician's orders, Resident #42 was supposed to use bilateral elbow pads when he was out of bed to prevent skin breakdown on his elbows.Review of a Physician's Order for Resident #42 with a reference date of 2/13/26 revealed Apply elbow pads bilaterally while up and remove when in bed.Review of a Skin Monitoring and Management-Pressure Ulcer policy with a reference date of 7/11/18 revealed .Prevention: In order to prevent development of skin breakdown.nursing staff shall implement.use of pressure relieving/reducing devices.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to implement care plan interventions for fall prevention for 1 (Resident #58) of 3 residents reviewed for accidents, resulting in the potential for falls and injury. Findings include:Resident #58Review of an admission Record revealed Resident #58 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out daily tasks), lack of coordination and muscle wasting (reduction in muscle mass, strength and function). Review of a Minimum Data Set (MDS) assessment for Resident #58 with a reference date of 4/23/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 1/15, which indicated the resident was severely cognitively impaired. Section J revealed Resident #58 had a fall with injury since the previous assessment.Review of a Care Plan for Resident #58 with a reference date of 2/18/26 revealed the following focus/goal/interventions: (Resident #58) is at risk for fall r/t (related to) medical condition, muscle wasting .history of sacrum (shield shaped bone at the base of the spine) fracture. Goal: (Resident #58) will remain free from fall related injury.Interventions.sign on walker that says please take me with you.be sure call light is within reach.During an observation on 5/4/26 at 9:44am, Resident #58 was asleep, lying on her right side with her torso resting on the upper half of her bed. Resident #58's feet were planted on the floor next to her bed. Resident #58's call light was under the foot of the bed, near the wall, out of reach. The resident's walker sat nearby with the brakes locked but there was no sign on the walker.During an observation on 5/4/26 at 12:53pm, Resident #58 sat at the edge of her bed and ate her lunch. Resident #58's call light remained under the foot of her bed, near the wall, out of reach. The resident's walker sat nearby with the brakes locked but there was no sign on the walker.During an observation on 5/4/26 at 3:26pm, Resident #58 sat at the edge of her bed. Her call light was under her bed, behind her feet, out of reach. The resident's walker sat nearby with the brakes locked but there was no sign on the walker.During an observation on 5/4/26 at 3:28pm, Resident #58 emerged from her room and walked into the hallway without her walker. The resident's walker sat nearby with the brakes locked but there was no sign on the walker.During an observation on 5/4/26 at 3:28pm, Licensed Practical Nurse (LPN) FF and Activity Assistant (AA) BB approached Resident #58, reminded her she needed to use her walker when she walked, encouraged the resident to sit back down on her bed and left the room after the resident was seated.During an observation on 5/4/26 at 3:30pm, Resident #58 sat at the edge of her bed, her call light remained on the floor, behind her feet, out of reach.In an interview on 5/4/26 at 3:57pm, Certified Nursing Assistant (CNA) II reported Resident #58 sometimes used the call light to alert the staff that she needed something.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement person-centered dementia care interventions based on lifelong habits and personality for 2 (Resident #63 and Resident #18) of 7 residents reviewed for dementia care, resulting in Resident #63 experiencing agitation and avoidable stress and Resident #18 breeching other residents' personal space, being yelled at and at risk for aggressive responses from others.Findings include: Review of The Unmet Needs Model, [NAME]-[NAME] and [NAME] (1995), revealed that those with dementia develop problem behaviors from an imbalance in the interaction between life-long habits and personality, current physical and mental states and less than optimal environmental conditions.Review of Revenge of the Introvert, Psychology Today 2010, revealed .Rather than being averse to social engagement, introverts become overwhelmed by too much of it. they.seem to process more information than others in any given situation. To digest it, they do best in quiet environments, interacting one on one. Solitude, quite literally, allows introverts to hear themselves think.Review of Nicotine Withdrawal, https://my.clevelandclinic.org/health/diseases/21587-nicotine-withdrawal, revealed Nicotine withdrawal is the physical and psychological symptoms you feel when you.reduce use of nicotine. Common symptoms include cravings, irritability.feeling frustrated, angry.feeling anxious or jumpy.trouble concentrating.Resident #63Review of an admission Record revealed Resident #63 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: anxiety disorder (a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear, dread and worry that interferes with daily life), major depressive disorder (persistent low mood, sadness, or a significant loss of activities lasting at least two weeks), vascular dementia without behaviors (a declined in thinking skills caused by conditions that block or reduce blood flow to the brain) and personal history of nicotine dependence (a chronic, compulsive brain disorder resulting in a person becoming physically and psychologically addicted to nicotine).Review of a Minimum Data Set (MDS) assessment for Resident #63 with a reference date of 4/27/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Section D revealed Resident #63 reported feeling down, depressed, or hopeless 2-6 days of the 14-day assessment period. Section F of the MDS revealed it was very important to Resident #63 to do his favorites activities and to go outside when the weather was good.Review of a Care Plan for Resident #63 with a reference date of 4/15/26 revealed the following focus/goal/interventions: 1. Focus: (Resident #63) has a behavior concern r/t (related to) exhibition of behavior agitation with residents and staff. Goal: (Resident #63) will have fewer episodes.of yelling or threatening hitting or kicking.Interventions: (Resident #63) is a smoker. He may be craving a cigarette. Offer him a smoke break.offer (brand of soda), chocolate, and (brand of potato chips) when he is agitated.intervene as necessary to protect the rights and safety of others.2. Focus: (Resident #63) will need encouragement to meet emotional, intellectual, physical, and social needs.Goal (Resident #63) will attend/participate in activities of choice.Interventions:.record (Resident #63's) prior level of activity involvement and interests by talking.with family.provide a program of activities that are of interest and empowers (Resident #63) by encouraging/allowing choice, self-expression.During an observation on 5/3/26 at 10:36am, Resident #63 walked down the hall of the memory care unit; Resident #18 walked next to him while making rapid, continuous, incoherent vocalizations. Resident #18 walked on Resident #63's right side. While walking, Resident #63 made eye contact with the surveyor, raised his eyebrows and widened his eyes, then quickly brought his right fist tightly to his chest, pointed his right elbow outward, toward Resident #18 and made a rapid jabbing motion toward her with his elbow, indicating he wanted to hit the other her. Resident #63 rolled his eyes as he gestured toward the other resident. When queried if he was ok, Resident #63 (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Maybe!, then rolled his eyes, tilted his head toward Resident #18 and shrugged his shoulders.In an interview on 5/4/26 at 1:27pm, Registered Nurse (RN) K reported Resident #63 became frustrated with other residents when they walked near and/or made frequent vocalizations. RN K reported Resident #63 yelled Get out of here! at Resident #18 earlier on this date. When further queried, RN K reported Resident #63 usually sat in the same recliner in the common area each day and when Resident #18 got near him, or other residents were laughing nearby, Resident #63 became agitated. RN K reported she tried to place a storage shelf and end tables around Resident #63's chair to keep other residents from getting too close to him, but that proved ineffective. RN K reported recently she heard Resident #63 yelling and found him standing with a raised fist directed toward another resident that was near his chair. RN K reported most of the time, Resident #63 was agitated by Resident #18 because she walked near him quite often, picked up whatever items she saw and was very vocal.In an interview on 5/4/26 at 3:50pm, Social Worker (SW) H reported she coordinated individualized dementia care interventions to reduce stress responses (behaviors) for Resident #63. SW H reported Resident #63 had been happy lately and was very laid back. SW H confirmed she was not aware of any instances of Resident #63 becoming stressed by the presence of other residents in the last several weeks. When queried if staff ever encourage Resident #63 to go to an area that would provide less stimulation when he was stressed, SW H stated No, we don't want him to self-isolate.Review of the Medication Administration Record for Resident #63, with a reference period of February-May 5, 2026, revealed no documented episodes of Resident #63 demonstrating agitation toward other residents.During an observation on 5/3/26 at 12:11pm, Resident #63 sat in the common area in his favorite recliner, surrounded by residents playing a balloon batting game. Resident #63 refused to participate; his right knee bounced up and down rapidly throughout the time the activity was underway.During an observation on 5/4/26 at 2:15pm, Resident #63 sat in a recliner in the common area of the memory care unit, 7 other residents, 2 staff and 2 family members were present. The family members sat next to Resident #63 and assisted another resident with opening some gifts. The family members spoke cheerfully with excitement as the unknown resident opened her gifts, staff were talking with other residents, and the television was playing an animated movie. Resident #63 sat with a furrowed brow, his right knee bouncing up and down rapidly, his hands rested on the arms, gripping the armrests firmly. Resident #63 stared straight ahead. No intervention was offered to Resident #63.In an interview on 5/4/26 at 3:35pm, Licensed Practical Nurse (LPN) FF reported Resident #63 was easily agitated by other residents and various stimulus in the common area of the memory care unit. LPN FF reported Resident #63 appeared protective of the recliner he often used in the common area and yelled at others if they came near the area immediately surrounding the chair. LPN FF reported Resident #63 seemed stressed by the family members visiting their loved one near him on this date.During an observation on 5/5/26 at 9:16am, Resident #63 sat in a recliner in the common area of the memory care unit. The room was quiet; all residents in the room were resting. The television was playing softly. Resident #63 appeared calm, no expression on his face, his legs were still.In an interview on 5/4/26 at 9:38am, RN K reported Resident #63 used to like to smoke after meals and she knew some staff took him outside for smoke breaks, but it did not happen on a scheduled basis. RN K reported at times, Resident #63 would approach her by the medication cart, near the door he exited for smoke breaks, and his hands were shaking which she believed was symptom of him wanting to go outside to smoke. When Resident #63 approached her in that manner, she coordinated with staff so he could go outside to smoke. RN K reported Resident #63 could no longer consistently verbalize his needs. RN K stated When I'm here, I ask them (staff) not to offer.to take him out to smoke, unless he comes up to me and his hands are shaking. RN K reported she did not think Resident #63 remembered that he liked to smoke. RN K reported the physician had discussed potentially placing Resident #63 on a nicotine patch but that had not happened.In an interview on 5/4/26 at 10:31am, Activities Director (AD) EE confirmed it was important to gather information about each residents lifelong interests and social patterns from family members if the resident could not (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicate the information, because each resident should have individualized care.In an interview on 5/4/26 at 2:11pm, Activity Assistant (AA) BB reported Resident #63 did not like to participate in most group activities. AA BB reported Resident #63 was easily overwhelmed and frequently became agitated toward other residents while he was in the common area of the memory care unit. AA BB reported Resident #63 yelled at other residents when he was agitated, especially Resident #18.In an interview on 5/4/26 at 3:41pm Certified Nursing Assistant (CNA) GG reported Resident #63 regularly demonstrated agitation toward other residents in the common area, but appeared calm when he was in a quiet place and he liked to watch television in his room.In an interview on 5/5/26 at 8:30am, SW H reported Resident #63 has behaviors and will smoke to help with them, but she did not believe the behaviors were being documented. SW H reported Resident #63 was supposed to have scheduled smoking times. When queried, SW H reported she knew LPN FF took Resident #63 out to smoke when he worked. Director of Nursing (DON) B reported Resident #63's communications skills were declining but at times he voiced that he wanted a cigarette. DON B reported Family Member (FM) DD regularly took Resident #63 on a leave of absence and allowed him to smoke.In an interview on 5/5/26 at 8:56am, Licensed Practical Nurse (LPN) CC reported Resident #63 sat in the common area and watched television most of the time but was easily agitated by other residents and recently yelled, Shut the f### up! at other residents in the common area. LPN CC reported staff did not encourage Resident #63 to spend any time in his room because he would have to lay in his bed and anytime, he did so, he fell asleep. LPN CC reported having a recliner in Resident #63's room would very useful because he could watch television and not be disturbed by other residents. Review of a Provider Note for Resident #63 with a reference date of 4/2/26 revealed Agitation.Pt's (patient's) agitation is labile, unknown trigger at this time.Review of a Psychiatry Follow Up report for Resident #63 with a reference date of 4/8/26 revealed .progress notes show episodes of increased anxiety, agitation and confusion.facility staff report that he gets angry, irritable and may attempt to swat or kick when other residents are by him.He states, my mood has not been good.In an interview on 5/5/26 at 4:37pm FM DD reported? no one at the facility had asked him about Resident #63's lifelong preferences or leisure interests. FM DD reported throughout his life, Resident #63 preferred to keep to himself, and didn't enjoy being around crowds of people. FM reported he took Resident #63 on leave of absence regularly and upon returning to the facility, Resident #63 always wanted to smoke a cigarette. FM DD reported he though staff were assisting Resident #63 with smoking several times a day, per Resident #18's preference. FM DD reported Resident #63 had smoked for many years and it was important to him.Resident #18Review of an admission Record revealed Resident #18 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 #18 with a reference date of 2/26/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 2/15, which indicated the resident was severely cognitively impaired. Section E of the MDS revealed Resident #18 wandered daily and her wandering had worsened since the previous assessment.Review of a Care Plan for Resident #18 with a reference date of 6/2/25 revealed the following focuses/goals/interventions: 1. Focus: (Resident #18) spends time walking around in the unit pick up sensory items.Goal: (Resident #18) will participate in activities of choice 3-5 times daily.Interventions:.offer to set up table top activities for (Resident #18) to stack or fold.encourage (Resident #18) to participate in activities of interest such as music, picture books and sensory stimulation activities.2. Focus: (Resident #18) .exhibits wandering behavior.Goal: minimize risk of elopement. Interventions: (Resident #18) likes to go in and out of other peers rooms. Distractions (sic) and redirect (Resident #18) from going into and out of peers rooms.Identify pattern of wandering.provide visual reminders and or deterrents to high-risk locations. Of note, there were no interventions to address Resident #18 entering Resident #63's personal space or related to the (continued on next page)

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	05/05/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conflicts between Resident #18 and Resident #63.During an observation on 5/3/26 at 12:18pm, Resident #18 wandered into room [ROOM NUMBER] on the memory care unit. A resident within the room was heard yelling at Resident #18, Out, Out, Out!.During an observation on 5/5/26 at 11:59am, Resident #18 wandered into Resident #63's room. The Stop Sign door sign was not in place.Review of a Psychiatry Follow Up progress note for Resident #18 with a reference date of 4/22/26 revealed .Facility staff report she (Resident #18) wanders in and out of other residents' rooms.Review of a Philosophy of Dementia Care policy with reference date of 1/1/2020 revealed The dementia care philosophy within the facility embraces a person-centered, relationship-based approach which supports the quality of life that respects the dignity, identify and individual needs of each person.We are committed to understanding and meeting each person's needs, preferences, and desires in a safe environment that is tailored to meet his/her stage specific needs.Review of a Memory Care Program/Clinical Approach policy with a reference date of 1/1/2020 revealed .truly individualized care requires a shift from control of behavior to one more attuned to allowing and supporting the person to be his/her own unique self.Using the reasonable person concept, though Resident #63 could not verbally express his feelings, it is reasonable to assume he experienced frustration and anxiety when his lifelong preferences were not supported.Using the reasonable person concept, thought Resident #18 could not verbally express her feelings, it is reasonable to assume she would not want to experience being yelled at by other residents, would not want to risk being the target of additional acts of aggression, and would want support in respecting the personal space of others.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical records for 1 of 18 residents (Resident #5) reviewed for complete and accurate medical record documentation, resulting in the potential for staff and providers mismanaging care for residents. Findings include:Resident #5 Review of an admission Record revealed Resident #5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression and visual hallucinations. Review of Resident #5's Letters of Conservatorship dated [DATE] revealed that Resident #5 was appointed a conservator (A person or organization appointed by a court to manage the personal care, financial affairs, or both, of an adult who cannot handle these responsibilities independently.) The letter of conservatorship expiration date was [DATE] . Notice concerning letters of conservatorship. All new and reissued letters of conservatorship will expire annually, 8 weeks beyond after the anniversary date of the appointment of the conservator . Noted that [DATE] was the date of 8 weeks past [DATE], when the letter of conservatorship expired. During an interview on [DATE] at 1:56 PM, Social Worker (SW) H reported she was aware that Resident #5's conservatorship was expired. SW H reported she reached out to Resident #5's conservator for updated conservatorship paperwork on [DATE] and had not received any communication back. SW H reported she had not followed up since. SW H reported that the facility should review guardianship/conservatorship paperwork quarterly at resident care conferences. Review of Resident #5's Care Conference note dated [DATE] did not include notes regarding the discussion of Resident #5's conservatorship paperwork. Review of the facility's Advance Directive Action Plan dated [DATE] revealed, Assessment: The facility identified that updated guardianship paperwork was not being obtained, and code statuses were still being signed by the guardian on file. Action Steps: SW completed a guardianship audit to identify who we needed to request documents for . Status Report: Completed on [DATE]. SW reached out to guardians to request updated documents and verify code status signatures were appropriate . Status Report: Completed on [DATE]. Review of email dated [DATE] that SW H sent to Resident #5's conservator revealed, Hi (Name redacted), I was wondering if you could please provide the facility a copy of the updated guardianship paperwork for (Resident #5?) . no response by Resident #5's guardian was provided. Noted that SW H did not provide verification that she had reached out to Resident #5's conservator prior to [DATE], which conflicts with the facility's Advance Directive Action Plan which noted that SW H had reached out to all facility guardians/conservators to obtain updated paperwork on [DATE]. Review of email dated [DATE] received from Nursing Home Administrator (NHA) A sent to Resident #5's conservator revealed, Hi (name redacted) . I am the Administrator . I wanted to reach out and see if you are able to provide us with updated guardianship paperwork for (Resident #5) .During a follow up interview on [DATE] at 8:26 AM, SW H reported she had called Resident #5's conservator on [DATE], and that Resident #5's conservator did not realize that Resident #5's conservator paperwork was expired, and that she was going to follow up with the court regarding this. SW H reported that moving forward, she would be utilizing a spreadsheet to track paperwork that would be expiring soon so she could follow up with guardians sooner.