STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235708	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Free Bed Sub-Acute Rehabilitation	235 Wealthy Street Se, 5th Floor Grand Rapids, MI 49503

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure that they had Registered Nurse (RN) coverage for at least 8 consecutive hours a day for 2 of 30 days (4/26/26 and 5/9/26) reviewed for RN coverage. Findings include:A review of the Daily Staffing Pattern sheets, dated 4/11/26 to 5/12/26, revealed that Registered Nurse/ Licensed Practical Nurse (RN/LPN) hours were not separated by licensure. The Daily Staffing Pattern Sheets had Total Hours (RN) listed. However, those hours were total nursing hours worked versus RN and/or LPN hours worked.A review of the facility's employee list revealed the facility employed both RN's and LPN's.During an interview on 5/13/26 at 8:45 AM, the Nursing Home Administrator (NHA) stated she thought the Total Hours (RN)on the Daily Staffing Pattern sheets were only RN hours. She stated she was not aware all of the total nursing hours were included in that line item. The NHA stated she would look into it and have the person who does the staffing sheets separate RN and LPN hours.On 5/13/26 at 10:50 AM, the facility provided a breakdown of the RN and LPN hours from 4/11/26 to 5/12/26. The breakdown revealed that the facility did not have any RN coverage on 4/26/26 and 5/9/26.During an interview on 5/13/26 at 12:37 PM, Unit Manager (UM) C stated when RN management works the floor they have an alternate code they use to punch in to include the hours that they worked. He stated he would look and see if an RN worked on 4/26/26 and 5/9/26. UM C stated the Director of Nursing (DON) was off for a little bit on leave, but they had an interim DON that filled in during the week. UM C stated he would look and see if they had any RN coverage on 4/26/26 and 5/9/26.During an interview on 5/13/26 at 12:43 PM, UM C stated he confirmed that there were not any RN's on 4/26/26 and 5/9/26. UM C stated on 4/26/26 the RN had PTO (paid time off) and they didn't catch it. He also stated on 5/9/26 they had an RN scheduled but the RN mixed up his schedule and did not show up to work.

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Preadmission Screening (PAS)/Annual Resident Review (ARR) for a resident with a mental disorder for 1 (Resident #7) of one resident reviewed for PASARR.Findings include:Review of a Face Sheet for R7 revealed he admitted on [DATE] with pertinent diagnosis of Asperger's Syndrome, autistic disorder, post-traumatic stress disorder, and depression.Review of the PASARR Level I Screening dated 3/6/26 for R7 showed it classified R7 as a Hospital Exemption Discharge. Section II indicated that R7 had diagnoses of mental illness, had received treatment for mental illness, and had received one or more antipsychotic or antidepressant medications within the last 14 days. It also documented that R7 had a diagnosis of an intellectual disability or a related condition, such as epilepsy, autism, or cerebral palsy, which manifested before age [AGE].In an interview on 5/12/26 at 2:42 PM, Social Worker (SW) E confirmed that another PASARR should have been completed for R7 after the 30-day Hospital Exemption. SW E stated that this PASARR had been overlooked, completed an updated one on this date, and notified the appropriate entity. SW E added that most residents at the facility do not stay long and this one was inadvertently missed.

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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** This citation pertains to intake 2607622. Based on interview and record review the facility failed to provide adequate supervision to ensure the safety of a severely cognitively impaired resident with a high fall risk for 1 (R86) of 2 resident reviewed for supervision, resulting in the potential for injury. Findings include:Review of a Facility Reported Incident (FRI) dated 8/9/25 for R86 revealed Patient briefly walked outside of the facility unattended. No previous elopement history and patient is used to going outside with his wife. Patient was outside for 15 minutes then returned to the facility, no injuries. The Investigation Summary/Actions Taken: [R86] goes outside nearly every day with wife. He went outside without her and stayed under the awning up front from 12:23 PM to 12:37 PM. [Certified Nursing Assistant (CNA) C] saw him from his room and notified [Registered Nurse (RN) D], while Security was called to bring him in. On admission, [R86] was assessed to not be a risk for elopement.Review of a Face Sheet revealed R86 admitted to the facility on [DATE] with pertinent diagnoses of hemiplegia and hemiparesis (one-sided weakness), seizures, and cognitive social or emotional deficit following a cerebral infarction. Review of the Minimum Data Set (MDS) dated [DATE] for R86 revealed he was severely cognitively impaired and had limited range of motion on one side.Review of a Physical Therapy Progress Note dated 8/8/25 for R86 revealed: Precautions: Fall risk, [right] hemiparesis, expressive aphasia (a disorder that affects how you communicate) . Conducted care conference with social work and pt's (patient's) wife, [Name] to discuss d/c (discharge) recommendations. Currently, recommending pt's wife to be home with pt as much as possible d/t (due to) pt's poor safety awareness.Review of a Physical Therapy Progress Note dated 8/9/25 for R86 revealed: W/C (wheelchair) mobility performed at distances of 240' (feet), encouraging him to find his way to his room and use the unaffected UE (upper extremity) for propulsion.Review of the Care plan for R86 revealed the following:-High to moderate risk for falls related to gait/balance problems, initiated 8/7/25.-Mobility: Partial/Moderate assist x1 person for transfers. Wheelchair for all mobility, initiated 8/8/25.-Risk for Wandering/Elopement identified, initiated 8/9/25.-The resident has impaired cognitive function or impaired thought process, initiated 8/11/25. Cue, reorient and supervise as needed.In an interview on 5/12/26 at 1:22 PM, CNA C reported R86 had a speech impairment, but she could understand him. CNA C reported she informed R86 that if he let someone know, he could go outside. R86 went down the hallway in his wheelchair, waved to her, got into the elevator and went outside. CNA C was not sure if he signed himself out. CNA C reported she didn't think anything else about it. A little while later, CNA C went to R86's room and saw him outside from the 5th floor through the window in his room sitting in the courtyard. CNA C did not think it was a big deal until the nurse overheard that R86 was outside and called security. CNA C did not recall staff reporting R86 could not go outside and felt if they are capable to go outside they can. CNA C felt he was not in danger or incompetent.Review of a Nursing Progress Note dated 8/9/25 for R86 revealed: This nurse received a message on [Phone] from downstairs that pt (patient) was outside in the front of the facility. Pt was observed being seen from his room window in [room number] on the front lawn. Floor staff immediately went to retrieve pt. Security was contacted. Security made contact with the pt and escorted him back to the unit. Pt routinely goes outside with his wife, however did not this time. Pt was reminded about not going off of unit without help. Pt's wife was reminded as well. Consent was given from pt to apply (wander device).In an interview on 5/12/26 at 2:47 PM, RN D stated that he was in another resident's room when he heard the Aides talking as they looked for a male resident (R86) who was outside. RN D explained that he remembered a similar previous incident, activated the elopement plan, and reported the incident to the Nursing Home Administrator (NHA). He then checked the signˆout log and confirmed that R86 had not signed out. Security located R86, brought him back to the 5th floor, and placed a wandering device on him. RN D stated he could not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remember how R86 got down to the courtyard and did not recall receiving any notification from the Receptionist or Guest Services on the first floor. He also reported that he did not remember R86 being fully cognizant and stated that R86 should not have been outside alone.During an interview on 5/13/26 at 8:24 AM, the Director of Nursing (DON) stated that staff transferred R86 to the 5th floor after he had been an inpatient on the 3rd floor. She explained that R86 was familiar with the facility because his wife visited him and they regularly went outside together. She acknowledged his cognitive impairment. She said the therapy department would assess any supervision needs, although nursing staff can also assess and implement measures. When asked if R86 was safe to go outside alone, she said the Therapy Staff would consider him unsafe to do so. She agreed that if the floor staff (CNA's) had known he needed supervision, they would have paid closer attention to prevent him from leaving the floor. She confirmed that R86's Care Plan did not include information telling CNA's that he needed supervision. She also stated that staff stationed near the elevators working are present only during the week. She clarified that when R86 left the floor on 8/9/25-a Saturday-staff were not monitoring the elevators. When questioned about staff education after the incident, she later confirmed that the Social Worker received education regarding the timeliness of resident cognition assessments following the incident.In an interview on 5/13/26 at 9:11 AM, Social Worker (SW) E stated that R86 had a low BIMS (Brief Interview for Mental Status) upon admission and that staff deemed him incompetent on 8/12/25. SW E reported that since this incident, the nurses and CNA's now join the 11:00 AM morning huddles to ensure staff are meeting all residents' needs. She acknowledged the concern of allowing a resident with severe cognitive impairment, high fall risk, limited mobility, and limited speech to leave the unit and go outside unsupervised. She stated that R86 could be impulsive, especially when he wanted to do something. She added that he could be stubborn and strongly wanted to go to the coffee shop, as he routinely did with his wife when he was on another floor prior to admission to the 5th floor. SW E acknowledged that the residents on their unit differ significantly due to their shortˆterm stays and the potential for postˆhospitalization delirium too. When asked how this type of incident would be prevented in the future unless staff can access the care plan addressing cognitive status and supervision needs, SW E stated that they are now addressing this in their morning standˆup meetings. When questioned about the lack of staff stationed near the elevators on the weekends, SW E said that was a good point. In an interview on 5/13/26 at 9:11 AM, Social Worker (SW) E reported R86 did have a low BIMS (Brief Interview for Mental Status) upon admission and was deemed incompetent on 8/12/25. SW E reported that since this incident, they have the nurse and the CNA join the 11:00 AM morning huddles to ensure they are meeting all the residents needs. SW E understood the concern of a resident with severe cognitive impairment, a high fall risk with limited mobility and speech to leave the unit and go outside unsupervised and reported R86 could be impulsive especially when he wanted to do something. R86 could be stubborn and he really wanted to go to the coffee shop as he always did with his wife when he was on the other floor prior to admission to the 5th floor. SW E acknowledged the residents on their unit is much different due to their short term stays and even the potential for short term delirium post hospitalization. When asked how this would be prevented from happening again unless staff can access the care plan that would address their cognitive status and need for supervision, SW E reported she felt that is now being addressed in their stand-up meetings in the mornings.In an interview on 5/13/26 at 11:30 AM, Security Officer (SO) F reported he worked the day of 8/9/25 when he received a call for an elopement at 12:38 PM from the dispatch that the resident (R86) had been outside but no longer seen on the camera. Once he received a description of R86, he approached R86 who was in his wheelchair heading back to the [NAME] Entrance of building (the entrance near the elevators to get to the 5th floor).Review of the Security Incident Report dated 8/9/25 at 12:38 revealed the initial dispatch call was for an elopement. SAR (subacute rehab) alerted security to possible elopement of [room number for R86). Patient in surface lot area but not allowed to be outside.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview and record review, the facility failed to have 2025 Federal and State Agency survey results that are prominent and accessible to the public. Findings include:Review of the Survey binder near the elevator entrance of the facility revealed the last survey available for review was from an annual survey in 2024.In an interview on 5/12/26 at 3:13 PM, the Nursing Home Administrator (NHA) verified that the binder was missing surveys and stated that the surveys had been there, but someone may have removed them. The NHA stated she will add the missing surveys to the binder.Review of the survey history revealed there was a complaint survey conducted with citations and an exit date of 10/21/25 that was not located in the survey book and available for review.