

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 084020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 5/29/2025
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NAME OF PROVIDER OR SUPPLIER CLEARSTREAM REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 240 E NORTH ST HASTINGS, MI 49058
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F0000 SS=	INITIAL COMMENTS Clearstream Rehabilitation and Nursing Center was surveyed for a re-visit survey on 5/29/25. Census=83	F0000		
F0658 SS= E	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow professional standards of nursing practice for medication preparation and administration, for 1 resident (Resident #401) of 4 residents reviewed for administration of medication, resulting in a medication error and the potential for the affected resident not maintaining or achieving their highest practical physical well-being. Findings include: Resident #401 During an observation on 5/29/25 at 9:21 AM LPN "P" was on A Hall preparing medications for Resident #401. Meloxicam (anti-inflammatory medication) 7.5 mg (milligram) was retrieved from a medication card in the cart that was labeled with the resident's name and instructions to administer 1 pill twice a day. LPN "P" administered the medication to Resident #401. Review of Resident #401's "Physician Orders"	F0658		4/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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	<p>revealed, on 5/21/24 Meloxicam was changed from 7.5 mg twice a day to 15 mg once daily.</p> <p>In a subsequent interview on 5/29/25 at 9:30 AM, LPN "P" reported there were 2 medication cards of Meloxicam 7.5 mg and 2 cards of Meloxicam 15 mg in the medication cart. After reviewing Resident #401's orders, LPN "P" reported that the Meloxicam 7.5 mg had been discontinued on 5/21/25, and should have been removed from the cart. LPN "P" reported that she had not reconciled the medication dosage against the physician order when she was preparing the medication.</p> <p>In an interview on 5/29/25 at 9:54 AM, Director of Nursing (DON) "B" reported, on 5/11/25 the pharmacy recommended to change Resident #401's Meloxicam from 7.5 mg twice daily to 15 mg once daily, and the physician agreed. DON "B" reported that the physician discontinued the resident's Meloxicam 7.5 mg and wrote a new order for Meloxicam 15 mg once daily. DON "B" reported that the nurse that received the new 15 mg card, should have removed the 7.5 mg card from the card, to avoid confusion during medication pass.</p> <p>In an interview on 5/29/25 at 11:30 AM, ADON "C" reported they had performed audits of medication administration per the facility's plan of correction (POC) from the annual survey that exited on 4/2/25. ADON "C" reported that she observed medication pass from a distance and also observed individual nurses administering a couple medications at a time. ADON "C" reported that she had not recorded the dates, resident names, or medications that were observed during the audits, but did not have any concerns. ADON "C" reported that when a medication dose changes, the nurse should verify the new medication with the order, and then label the new medication card with an alert sticker.</p>			

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F0761 SS= D	<p>In an interview on 5/29/25 at 11:28 AM, Unit Manager (UM) "I" reported they had performed audits of medication cart storage per the facility's POC but did not regularly check for discontinued medication cards.</p> <p>Review of Fundamentals of Nursing (Potter and Perry) revealed, "Professional standards such as Nursing: Scope and Standards of Practice (ANA, 2010) ...apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these six rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation." Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations 39307-39313). Elsevier Health Sciences. Kindle Edition.</p> <p>Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive</p>	F0761		4/30/2025	

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	<p>Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to properly label, date, and store medications in 2 of 2 medications carts, resulting in the potential for decreased efficacy of medications, the exacerbation of medical conditions, medication errors, and narcotic diversion.</p> <p>Findings include:</p> <p>During an observation on 5/28/25 at 10:09 AM observed medication cart on Hall B. The narcotic count sheets were reviewed and there was no record of the count being verified on 5/28/24. The last count entry was 5/27/25 at 10:00 PM.</p> <p>In an interview on 5/28/25 at 10:18 AM, Assistant Director of Nursing (ADON) "C" reported that at the beginning of each shift a narcotic count should be performed and recorded by the outgoing and incoming nurses. ADON "C" discussed the concern with Licensed Practical Nurse (LPN) "M".</p> <p>In an interview on 5/28/25 at 10:21 AM, LPN "M" reported that normally the outgoing nurse (LPN "N") would sign and date when she left at 6:00 AM, but she probably couldn't find a log sheet to document on. LPN "M" reported that she had not counted narcotics that day.</p> <p>An attempt was made on 5/29/25 at 11:46 AM to</p>			

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	<p>interview LPN "M" but there was no return phone call.</p> <p>During an observation on 5/29/25 at 9:21 AM LPN "P" was on A Hall preparing medications for Resident #401. Meloxicam (inflammation and pain reliever) 7.5 mg was retrieved from a medication card in the cart that was labeled with the resident's name and instructions to administer 1 pill twice a day. LPN "P" administered the medication to Resident #401.</p> <p>Review of Resident #401's "Physician Orders" revealed that on 5/21/24 Meloxicam was changed from 7.5 mg twice a day to 15 mg once daily.</p> <p>In a subsequent interview on 5/29/25 at 9:30 AM, LPN "P" reported there were 2 medication cards of Meloxicam 7.5 mg and 2 cards of Meloxicam 15 mg in the medication cart. After reviewing Resident #401's orders, LPN "P" reported that the Meloxicam 7.5 mg had been discontinued on 5/21/25, and should have been removed from the cart so that it wasn't accidentally administered.</p> <p>In an interview on 5/29/25 at 9:54 AM, Director of Nursing (DON) "B" reported the nurse that received the new 15 mg card, should have removed the 7.5 mg card from the card, to avoid confusion during medication pass.</p> <p>In a subsequent observation of Hall A medication cart on 5/29/25 at 10:00 AM a used Insulin pen was found without an open date. LPN "P" reported that she had used the pen that morning and forgot to date it.</p> <p>In an interview on 5/29/25 at 11:30 AM, ADON "C" reported she had performed audits of medication administration per the facility's plan of correction (POC). ADON "C" reported that when a medication dose changes, the nurse</p>			

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	<p>should verify the new medication with the order, and label the medication card with an alert sticker.</p> <p>In an interview on 5/29/25 at 11:28 AM, Unit Manager (UM) "I" reported she had performed audits of medication cart storage per the facility's POC. UM "I" reported weekly checks of eyedrops, insulin, inhalers, and over the counter medications. UM "I" reported that she did not regularly check for discontinued medication cards. UM "I" reported that insulin pens should be dated immediately when they are opened.</p>				