STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER: The Springs at Rochester Hills Rehab & Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 1480 Walton Blvd Rochester Hills, MI 48309	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #s MI000151156 and MI00151228. Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for two (R705 and R704) of three residents reviewed for abuse, resulting in R703 punching R704 and R705 on their face with a closed fist. Findings include: Resident to Resident incident on 3/9/25 between R703 and R704: Review of a Facility Reported Incident (FRI) for a Resident to Resident incident submitted to the State Agency (SA) on 3/8/25 documented, in part: .On 3/8/2025 [R703] was walking down the hallway on the 2 North unit towards [Nurse 'A'], reached over her shoulder, and punched Resident [R704] with a closed hand fist in the right side of the face .Resident [R704] revealed she has swelling to the right side of her face near her lower jaw and states it is painful. Resident is unable to give a number from the pain scale rating but states, It hurts, and points to the right side of her face . Further review of the facility's conclusion to this incident documented, in part: .While facility acknowledges contact was made between the two residents, facility verified that intent abuse did not occur. Abuse could not be verified . Review of R703's clinical record revealed the resident was initially admitted into the facility on [DATE] and recently discharged to a local hospital on 3/9/25 with diagnoses that included: conversion disorder with seizures or convulsions, metabolic encephalopathy, unspecified dementia, paranoid schizophrenia, and undifferentiated schizophrenia. According to the Minimum Data Set (MDS) assessment dated [DATE], R703 had severe cognitive impairment, had behavioral symptoms not directed towards others which occurred daily, and had wandering behavior of this type which occurred daily. Review of R703's progress notes included: (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry for 3/8/25 at 3:08 PM which read, Per [Nurse 'A'] .Patient assaulted a female resident, by striking her in the face with a closed hand fist . Review of R704's clinical revealed R704 was initially admitted into the facility on [DATE], and was receiving hospice services. Diagnoses included: senile degeneration of brain, not elsewhere classified, encounter for palliative care, restlessness and agitation, and psychotic disorder with delusions due to known physiological condition. According to the MDS assessment dated [DATE], R704 had severe cognitive impairment, had no mood or behavioral concerns, and had no hallucinations/delusions. Review of R704's progress notes included: An entry on 3/8/25 at 3:41 PM by [Nurse 'A'] which read, Patient struck in the face with a closed fist to the right side of her face by another resident . Resident to Resident Incident on 3/8/25 between R703 and R705: Review of a Facility Reported Incident (FRI) for a Resident to Resident incident submitted to the State Agency (SA) on 3/8/25 documented, in part: .On 3/9/2025 [Nurse 'E'] witnessed [R703] come out of his room to the hallway, agitated and yelling. [R703] walked over to [R705] who was also in the hallway and punched her with a closed fist in the right cheek . Further review of the facility's conclusion to this incident documented, in part: .While facility acknowledges contact was made between the two residents, facility verified that intent abuse did not occur. Abuse could not be verified . Review of the clinical record revealed R705 was initially admitted into the facility on [DATE] and readmitted on [DATE] and was receiving hospice services. Diagnoses included: Alzheimer's disease, macular degeneration, psychotic disorder with delusions due to known physiological condition, generalized anxiety disorder, dysphagia, and depression. According to the MDS assessment dated [DATE], R705 had moderate cognitive impairment, had no mood or behavioral concerns, and had no hallucinations/psychosis. Review of R705's progress notes included: A late entry on 3/9/25 at 3:51 PM read, .Resident was at the nurse's station at approx. (approximately) 1530 (3:30 PM) when resident [R703] walked out of his room after resting in bed. Resident [R703] walked up to the resident and hit her with a closed fist . Review of R703's progress notes included: An entry on 3/9/25 at 4:00 PM read, Resident was violent and aggressive toward his fell ow resident . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An entry on 3/9/25 at 6:00 PM read, .Resident noted to be in room with a 1:1 with staff. Resident yelling out and shouting. Unable to make sense of the verbiage <sic>. Resident noted to be hitting self in head This author spoke with physician and new order to petition resident out to hospital r/t (related to) physical with others. Non-emergent transfer arranged, police and ems (Emergency Medical Services) arrived at 1815 (6:15 PM) to transport resident to hospital . On 3/27/25 at 1:15 PM, an interview was conducted with the Administrator (Abuse Coordinator) and the Director of Nursing (DON). When asked about both resident to resident incidents between R703 to R705 and R703 to R704, both the DON and Administrator confirmed the incidents occurred as documented in their investigation. When asked why abuse was not substantiated for either incidents, both the Administrator and DON reported they felt there was no intent due to poor cognition, no harm and the resident's not being able to recall the incidents. When asked about why R705's complaint of pain, swelling and need for facial x-ray to rule out injury would not be considered harmful, the DON reported there were no outcomes from the x-ray. The Administrator reported they were newer to the position as an Administrator and was deferred to review their abuse policy and current regulatory language involving resident to resident incidents, including residents with cognitive impairment. According to the facility's policy titled, Abuse and Neglect dated Revised 6/17/2019: .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes .physical abuse .Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .

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F 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident must receive and the facility must provide necessary behavioral health care and services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41415

Based on interviews and record reviews the facility failed to ensure nonpharmacological interventions were implemented and utilized before the administration of pharmacological interventions, failed to implement a person centered behavioral care plan, and failed to provide behavioral health services to one (R702) of three residents reviewed for falls. Findings include:

Review of a complaint submitted to the State Agency (SA) documented a concern of multiple falls for R702 that led to hospitalization .

A review of the medical record revealed R702 was admitted to the facility on [DATE], with diagnoses of a traumatic brain injury, acute respiratory failure, acute embolism and thrombosis, and major depressive disorder.

Review of a care plan titled . risk for falls . documented the following intervention:

. When showing increased anxiety offer PRN (as needed) anxiolytic and monitor for safety awareness after administration . Date Initiated: 03/03/2025 .

A review of the medical record revealed no diagnosis of anxiety for R702.

Review of the physician orders revealed a behavioral consultation order implemented on 2/17/25.

A review of the medical record revealed no documentation of a behavioral consultation to have been completed.

Review of the March 2025 Medication Administration Record (MAR) documented the following:

Lorazepam 0.5 mg (milligram), one tablet by mouth every 12 hours as needed for anxiety.

This medication was documented as administered on 3/2/25 at 9:18 AM, by Registered Nurse (RN) K.

RN K was not on duty at the time of the survey and was not interviewed.

A review of the progress notes revealed the following:

3/2/25 at 9:18 AM- . Lorazepam . 0.5 mg . administered .

3/2/25 at 9:58 AM- . Lorazepam . 0.5 mg . PRN Administration was: Effective .

Review of the medical record revealed no documentation on what behaviors or moods was identified with R702 that warranted the administration of the Lorazepam medication. The record revealed no consent obtained to start the Lorazepam medication.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed no documentation of non-pharmacological interventions attempted before the administration of the Lorazepam medication. Review of the care plans revealed no documented interventions or care plan implemented for anxiety. On 3/27/25 at 1:14 PM, the Director of Nursing (DON) and Administrator was interviewed and asked about the Ativan implemented as an intervention for falls. The DON and Administrator was asked how Ativan medication could be ordered and administered to R702 who did not have a medical diagnosis of anxiety and had no targeted behaviors/moods identified that would warrant the administration of Ativan. The DON and Administrator was asked about the lack of a resident centered anxiety care plan and non-pharmacological interventions. Lastly the DON and Administrator was asked if R702 was ever seen by their behavioral services group. The DON and Administrator stated they would look into the concerns and follow back up. At 2:50 PM, the DON and Administrator returned. The DON stated they spoke to RN K who stated they administered the Ativan to R702 because the resident kept calling out for water and they were unable to redirect the resident. The DON stated that RN K called the Physician, who ordered the Ativan and RN K administered it. The DON stated it was not the facility's protocol to handle the incident in that manner and will be conducting further education with the staff to ensure non pharmacological interventions are utilized and all necessary components are in place prior to the administration of a psychotropic medication. No further explanation or documentation was provided by the end of the survey. Review of a facility policy titled Behavioral Health Services dated 7/11/18, documented in part . It is the policy of this facility that each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care . Review of a facility policy titled Psychoactive Drug Use dated 7/11/18, documented in part . PURPOSE . To maintain every resident's right to be free from chemical restraints . To ensure that no drug is used in excessive dose, for an excessive duration, or without adequate monitoring, or without indications for its use . No psychoactive drugs will be utilized without a diagnosed specific condition . Psychoactive drugs will be considered only after alternative measures and/or consultation with appropriate health professionals has been made .