

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  07/15/2025
NAME OF PROVIDER OR SUPPLIER  The Springs at Rochester Hills Rehab and Nursing C		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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake: 1290771. Based on observation, interview and record reviews the facility Administration failed to follow the facility's policy regarding grievances and failed to follow up regarding reported concerns for one (R804) of one resident reviewed for grievances. Findings include:A review of a complaint submitted to the State Agency (SA) documented concerns about the Administration staff failure to follow up with the family on multiple occasions regarding verbalized concerns. On 7/15/25 at 9:30 AM, R804 was observed lying in bed. A brief interview was conducted with the resident at that time. A review of the medical record revealed R804 was admitted to the facility on [DATE], with diagnoses that included: epilepsy, dementia and cognitive communication deficit. A review of a Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 9 which indicated moderately impaired cognition and required staff assistance for all ADLs. Further review of the medical record revealed the resident's mother and sister as their appointed legal guardians.Review of a grievance provided by the Administrator documented in part . family member states resident need to be changed more frequently and would like catheter to be monitored better. Investigation- Orders and treatments and care plans were verified for accuracy and will continue to be followed. Resolution- Annual competencies and education completed and/or scheduled for needed staff per policy. Notifications. Date Complainant Notified of Resolution 6/25/25. Family Satisfied NO, if no, please explain: Will continue to follow care plan and update family with changes.There was no documented follow up with the resident's responsible party, who verbalized their concerns. A review of a facility policy titled Grievances updated 5/2/19, documented in part . It is the policy of this facility to investigate all grievances registered by, or on behalf of a resident. The Administrator or designee in the absence of the administrator, shall confer with persons involved in the incident and other relevant persons and within three to seven days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party. an oral explanation shall accompany the written one. The Administrator or designee in the absence of the administrator, will make contact with the concerned party within 24 hours of being made aware of the grievance to let them know you are aware, that an investigation is being conducted, and to ask any additional question that may help you come to a resolutions and will keep in frequent contact until a resolution is obtained.On 7/15/25 at 3:28 PM, the Administrator was interviewed and asked why the facility's policy and protocol for grievances pertaining to the grievance provided for R804 was not followed, specifically following up with the family regarding their concerns. The Administrator stated they obtained the grievance on their last day in the facility before their assigned time off leaving the Director of Nursing (DON) in charge of following up on the grievance. At the time of the survey the DON was off duty. The Administrator acknowledged the concern. No further explanation or documentation was provided by the end of the survey.</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake Number(s): 1290904. Based on observation, interview, and record review, the facility failed to follow their abuse policy to address a witnessed resident to resident physical altercation between two (R801 and R802) of five residents reviewed for abuse, resulting in R815 attempting to intervene and stop the altercation. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency on 6/23/25 revealed there was a resident-to-resident incident between R801 and R802. On 7/15/25 at 10:48 AM, R802 was observed sleeping. Certified Nursing Assistant (CNA) 'G' was observed standing outside of R802's room. CNA 'G' reported R802 was on one to one supervision because I think he punched someone. CNA 'G' reported he stood outside the door and if R802 left the room, he followed him. CNA 'G' stated, I don't know. They didn't give me all the details. On 7/15/25 at 12:34 PM, R801 was observed seated on his bed. When queried about any physical altercations that occurred with another resident, R801 appeared paranoid and stated, What is this really about? R801 said he did not want to talk about it and did not know what happened anyway. R801 reported he was sent to the hospital but said he did not know why. A review of R801's clinical record revealed R801 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia, bipolar disorder, paranoid schizophrenia, and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had severely impaired cognition and no behaviors. A review of R801's progress notes revealed R801 was transferred to the hospital on 6/23/25. A review of a behavioral health note dated 6/24/25 revealed notation that R801 was readmitted after a fall and he was seen for follow up after a resident-to-resident incident. The note documented, said that he hit the other resident to defend himself. A review of R802's clinical record revealed R802 was admitted into the facility on 6/20/23 and readmitted on [DATE] with diagnoses that included: dementia, psychotic disorder with delusions, schizoaffective disorder, and traumatic brain injury. A review of an MDS assessment dated [DATE] revealed R802 had moderately impaired cognition and verbal behaviors. A review of an investigation conducted by the facility revealed on 6/23/25, R815 observed R802 and R801 on the floor in the hallway and approached them to assist them because it appeared they were having a disagreement and were swinging their arms towards each other. It was noted that both residents sustained minor abrasions and were sent to the hospital. A typed statement from R815, signed by the Administrator (not R815) noted, I was walking down the hallway towards the dining room when I saw (R802) and (R801) on the floor in the hallway .swinging their arms towards each other while they were laying on the ground. as I was getting in between them to get them to stop and help them up (Registered Nurse - RN 'H') (Licensed Practical Nurse - LPN 'I') and (Staffing Coordinator - SC 'D') were approaching us and assisted with separating the residents and escorting them back to their rooms. I'm not sure why they were on the ground or what the disagreement was about .A typed statement, signed by the Administrator, for R802 revealed R802 did not remember why they were on the ground. A typed statement, signed by the Administrator, for R801 revealed the following documentation, I was just walking in the hallway towards the nurse's station to ask my nurse for something for pain because my back hurt .I saw (R802) coming behind me from the other end of the hall. When he got close to me, he started calling me profane names .told him not to touch me .said he would do whatever he wanted .started to argue and push each other until we lost our balance and landed on the floor .we were both struggling to get up and the nurses came to help us up and we went back to our rooms .A typed statement from LPN 'I', signed by the Administrator documented, . (RN 'H') came down the hallway from the opposite direction and said two residents were on the ground on the other end of the hallway .observed (R815) standing up in between (R802) who was on the floor in a seated position and (R801) who was also on the floor in a seated position attempting to assist them to a standing position .A typed statement from SC 'D', signed by the Administrator documented, .At nurse's station when (RN 'H') came from the other end of the hall and said he was two residents (R802 and R801) on the floor in the hallway towards the end .A typed statement from RN 'H', signed by the Administrator, documented, .at the end of the hallway on 1 North and looked over and saw tow residents on the floor down the 1 North East Unit with a third resident standing between them .immediately went that way passing the nurse's station on the 1 North Unit and alerting the other staff members in the area .On 7/15/25 at 1:15 PM, an interview was conducted with R815. R815 confirmed he witnessed the physical altercation between R801 and R802 on 6/23/25. R815 said he came out of his room and saw them standing down the hall punching each other .R815 explained he ran down toward the residents and the male</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake: 1290771. Based on observation, interview and record reviews the facility failed to provide assistance with grooming for one (R804) of two residents reviewed for Activities of Daily Living (ADLs). Findings include: A review of a complaint submitted to the State Agency (SA) documented concerns about the lack of staff assistance to maintain R804's grooming and hygiene. On 7/15/25 at 9:30 AM, R804 was observed lying in bed. R804 was observed with lots of facial hair and in need of a shave. A brief interview was conducted with the resident at that time. A review of the medical record revealed R804 was admitted to the facility on [DATE], with diagnoses that included: epilepsy, dementia and cognitive communication deficit. A review of a Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 9 which indicated moderately impaired cognition and required staff assistance for all ADLs. Further review of the medical record revealed the resident's mother and sister as their appointed legal guardians. Review of a care plan titled I have an ADL self-care performance deficit. documented the following intervention created on 9/27/23 Family requests he be clean shaven. A review of the Certified Nursing Assistant (CNA) documentation titled Personal Hygiene that included . Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving. revealed the task was signed off as completed on 7/14/25 at 6:09 AM, 2:59 PM &amp; 10:59 PM and again on 7/15/25 at 5:53 AM. The surveyor observation on 7/15/25 of the resident revealed the resident's facial grooming had not been completed per the plan of care, despite to have been signed off as completed by multiple CNAs. Review of the CNA task document noted in part . Personal hygiene: Dependent x1 person assist. This indicated the resident required staff assistance for this task. On 7/15/25 at 2:55 PM, Unit Manager (UM) C was interviewed (in absence of the facility's Director of Nursing-DON) and asked about the resident's plan of care regarding the family's request to be kept clean shaven, the CNA's documentation of completing the task three times on each shift on 7/14/25 and once on the morning of the survey 7/15/25 and the resident observation of a face full of facial hair observed on the morning of 7/15/25. UM C stated they would expect their staff to shave the resident during morning care. UM C stated they would follow up with the concern. No further explanation or documentation was provided by the end of the survey.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>This citation pertains to Intake Number(s): 1290771. Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff to meet the needs of 11 (R804, R805, R806, R807, R808, R809, R810, R811, R812, R813, and R814) of 11 residents reviewed for staffing, resulting in residents not receiving water for two days, residents wandering into other residents' rooms, incorrect meal trays being delivered and/or left in the residents' rooms for extended periods of time, and staff being unaware of their assignments. This had the potential to affect all residents who resided on the second floor. Findings include: On 7/15/25 at 9:34 AM, R805 was observed lying in bed. A breakfast tray was observed on R805's over bed table with a meal ticket dated 7/14/25 with R804's name (a resident who resided in a room across the hall from R805). A meal ticket with R805's name dated 7/11/25 was observed on the table. A disposable cup was observed on R805's nightstand, not within reach of R805 dated 7/13/25 3-11pm, two days prior. When asked, R805 was unable to say whether she ate breakfast that day or not (7/15/25).</p> <p>On 7/15/25 at approximately 9:40 AM, Hospice Nurse 'E' was observed in R805's room. Hospice Nurse 'E' moved R805's over bed table over R805's bed and set up the tray with R804's meal ticket on it for R805. When queried about why R805 had R804's breakfast tray, Hospice Nurse 'E' said she was just here from hospice and was about to check on the tray.</p> <p>On 7/15/25 at 9:45 AM, an interview was conducted with Registered Nurse (RN) 'A', the nurse assigned to R804 and R805. When queried about who was responsible to pass meal trays and water to residents, RN 'A' reported the Certified Nursing Assistants (CNA) were responsible. RN 'A' said CNA 'F' was assigned to the back part of the hall where R804 and R805 resided.</p> <p>On 7/25/25 at 9:50 AM, an interview was conducted with CNA 'F'. When queried about who passed trays to the hallway where R804 and R805 resided, CNA 'F' reported she passed the trays. When queried about which residents they were assigned to CNA 'F' reported she was not sure because her assignment changed. CNA 'F' reported they were short one CNA on the second floor (2 North [NAME] Unit), but another CNA was supposed to come in. CNA 'F' was not sure if the third CNA came in yet or who she was responsible to care for. CNA 'F' reported her shift began at 7:00 AM. When queried about any care or services provided between 7:00 AM and 9:50 AM, CNA 'F' reported she arrived at 7:00 AM and had to give a resident a shower right away because they were soiled. When queried about who she passed meal trays to, CNA 'F' reported the other CNA (CNA 'B') assisted with passing trays, but thought she only passed a tray to one room (R804). CNA 'F' reported she had not yet passed any water to residents as of 9:50 AM. When queried about whether R805 received breakfast, CNA 'F' did not know.</p> <p>On 7/25/25 at approximately 9:52 AM, an interview was conducted with CNA 'B'. CNA 'B' reported she was assigned to other side of the unit. When queried about whether any water was passed on the second floor or if she passed any trays on the other hallway, CNA 'B' reported she only passed trays to one room on the other side and confirmed it was not to R804 or R805.</p> <p>Additional observations of the second floor unit between 9:34 AM and 10:05 AM revealed the following:</p> <p>R807 did not have any water available in their room.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R808 was observed with an empty disposable cup, undated, and not within reach of the resident.</p> <p>R810 was observed with a disposable cup dated 7/13/25 3-11:00 PM.</p> <p>R811 did not have any water available in their room.</p> <p>R809 was observed with an empty, undated disposable cup.</p> <p>R813 was observed with a disposable cup dated 7/13/25.</p> <p>R814 was observed with an undated disposable cup not within reach of the resident.</p> <p>On 7/15/25 at 9:40 AM and 9:54 AM, R806 was observed wandering into two different residents' rooms and was not redirected by staff.</p> <p>On 7/15/25 at 10:06 AM, SC 'D' was further interviewed. SC 'D' explained the second floor was short one CNA that day because a CNA was running late. SC 'D' reported they had to call someone else in to cover, but there were only two CNAs up there for the first part of the shift. When queried about what the facility implemented to ensure the unit was adequately staffed until the third CNA arrived, SC 'D' said if there was an extra nurse (and confirmed there was not on that day) they would take the set until the other CNA got there, or SC 'D' or UM 'C' would cover. When queried about whether they took the extra set until the third CNA got there, SC 'D' reported she passed one meal tray which was the same room CNA 'B' said she passed a tray to. SC 'D' reported she did not assist with anything else. When queried about why, SC 'D' reported it was discussed with UM 'C' and they decided the two CNAs (CNA 'B' and CNA 'F') would just split all of the rooms.</p> <p>On 7/15/25 at approximately 11:00 AM, an interview was conducted with UM 'C'. When queried about how the second floor is managed when it was short staffed, UM 'C' reported herself, SC 'D' or the floor nurse would fill in if short. When queried about whether she took the extra set on the second floor today before the third CNA arrived, UM 'C' reported she did not, and they decided along with SC 'D' to just have CNA 'F' and CNA 'B' split the residents. When queried about the lack of fresh water since 7/13/25, UM 'C' reported she was not aware. UM 'C' reported the CNAs could have asked for help if they needed it.</p> <p>On 7/15/25 at 3:40 PM, an interview was conducted with the Administrator. When queried about the facility's protocol to ensure there was sufficient nursing staff to provide care and services to the residents, the Administrator reported the nurses, Unit Manager, or Staffing Coordinator should step in to assist. The Administrator reported the CNAs could have asked for help on the second floor, if needed. When queried about whether UM 'C' should have recognized that waters were not passed since 7/13/2, the Administrator reported she would have expected that to be identified.</p> <p>A review of R804's clinical record revealed they had a diagnosis of dementia.</p> <p>A review of R805's clinical record revealed they had a diagnosis of dementia and a history of wandering into other residents' rooms.</p> <p>A review of R807's clinical record revealed they had a diagnosis of dementia.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of R808's clinical record revealed they had a diagnosis of dementia.</p> <p>A review of R810's clinical record revealed they had a diagnosis of dementia.</p> <p>A review of R811's clinical record revealed they had a diagnosis of Alzheimer's Disease.</p> <p>A review of R813's clinical record revealed they had diagnoses that included: dementia and adult failure to thrive.</p> <p>A review of R814's clinical record revealed they had diagnoses that included: chronic kidney disease, adult failure to thrive, and hypokalemia (low potassium).</p> <p>On 7/15/25 at 9:37 AM, R806 was observed in the room of R's 803 &amp; 804. The resident was observed standing in the middle of R's 803 &amp; 804 room. None of the staff was observed to have identified that R806 was in a room that was not their own. R806 was asked their name, and they provided it. When asked if there was anything that they needed, R806 exited the room and began wandering down the hallway entering and exiting multiple rooms that were not their own. A nurse and two Certified Nursing Assistants (CNAs) were observed in the hallway, however no one attempted to redirect R806.</p> <p>A brief record review revealed that R806 had a diagnosis of dementia.</p> <p>On 7/15/25 at 9:40 AM, Registered Nurse (RN) "A" was interviewed and asked if they felt the facility provided adequate staffing on their unit for them to timely and safely complete their duties. RN "A" replied their workload was heavy considering the population on the unit. RN "A" stated there are days when medications are not given timely due to their workload.</p> <p>RN "A" was identified to be the only assigned nurse on the second floor (memory care/dementia) unit with 31 residents, with some requiring constant supervision and/or redirection. Also assigned to the unit were three agency CNAs (Certified Nursing Assistants).</p> <p>On 7/15/25 at 9:49 AM, CNA "B" was interviewed and asked if they felt the facility had enough staff on duty for them to safely complete their duties and to provide quality care. CNA "B" replied they were from an agency, and it was their first time at the facility. CNA "B" stated they hadn't had the chance to provide their assigned residents with water or their breakfast trays because they were cleaning the resident rooms. CNA "B" stated they had gotten one resident up that had bowel movement all over their bedding and sheets. CNA "B" stated when they removed the resident's brief the resident had not had a bowel movement so what they were cleaning had to be from a bowel movement the resident had on a previous shift. CNA "B" explained how they have been stripping the residents' beds to apply clean bedding.</p> <p>On 7/15/25 at 9:45 AM, R809 was observed sitting back in a geri chair alongside the hallway wall. In front of the resident was a bedside table over their lap. On the bedside table was a white Styrofoam cup dated "7/13/25, 3-11 PM, (resident room number)" This indicated the resident water cup was two days old.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/15/25 at 9:54 AM, Unit Manager (UM) " (the unit manager for the second floor- memory care/dementia unit) was interviewed and asked if they felt that one nurse and three cnas were adequate staffing for the second floor. UM " stated they believed one nurse to 31 residents was "doable". When asked if they considered the acuity of those 31 residents to the ratio of one nurse, considering the observations of the wandering residents, fresh water to not have been provided to the residents in two days and the delay in providing the breakfast trays to the residents UM " acknowledged the concern and stated they were following up.</p> <p>On 7/15/25 at 10:06 AM, the Staffing Coordinator (SC) " was interviewed and asked how they determine and assigned the staffing needs for the second floor of the facility. SC " replied staffing had been a challenge at the facility due to not being able to retain staff. SC " stated the facility utilized agency staff to help. SC " stated they schedule the staff "solely based on the census" of the facility. SC " explained due to the second floor not being fully occupied they schedule one nurse with two aides for midnight and one nurse with three aides for day and evening shifts. SC " was asked if they ever took into consideration the acuity of the second-floor unit when staffing and SC " stated they staff off of the facility's census and if the census fluctuates then the staffing will fluctuate.</p> <p>Review of a facility policy titled "Staffing" dated 7/11/18, documented in part " Our facility provides adequate staffing to meet needed care and services for our resident population" Our facility maintain adequate staffing on each shift to ensure that our resident's needs and services are met"</p>		