STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235036	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Rochester Hills Rehab and Nursing C	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 - 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. (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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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 263088. Based on observation, interview and record review, the facility failed to protect the residents' right to be free from physical abuse by a resident for three (R801, R802, and R803) of three residents reviewed for abuse, resulting in R801 punching R802 in the face twice breaking R802's jaw and R802 pushing R803 to the floor, then kicking R803 and trying to run R803 over in their wheelchair. Findings include:Review of the facility reported documentation submitted to the State Agency on 9/21/25 included an incident summary of a resident to resident physical altercation which read, On 9/20/25 at approximately 5:50pm Nurse was at medication cart in the hallway. She heard a commotion and when she turned around she observed [R801] make contact with [R802] in the face with a closed hand.Staff completed a skin and pain assessment on [R802] with notation of slight redness, res (resident) did not resent with any pain. It should be noted that the information submitted as above did not accurately represent the extent of the events that were documented on witness statements and included in the electronic medical record (EMR).R801 & R802On 10/7/25 at 9:00 AM, the Administrator was requested to provide facility documentation of the resident to resident altercation that occurred between R801 and R802 on 9/20/25.On 10/7/25 at 9:54 AM, R801 was observed walking independently in the hallway near the elevator and upon approach agreed to go to their room to talk. When asked if they could recall any incident in which they punched another resident in the face, R801 reported Yes, she pushed right into me when I was going by. I was moving past her wheelchair and she grabbed me. No, she didn't grab me, kinda pushed against me and I hit her back. When asked what happened after that, R801 stated, Called the police on me.Review of the clinical record for R801 revealed the resident was initially admitted into the facility on 5/1/18 with diagnoses that included: unspecified dementia, unspecified severity, with other behavioral disturbance, undifferentiated schizophrenia, cognitive communication deficit, dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance, and adjustment disorder with anxiety.According to the Minimum Data Set (MDS) assessment dated [DATE], R801 had no communication concerns, had severely impaired cognition (scored three out of 15 on the Brief Interview for Mental Status/BIMS exam), had disorganized thinking which fluctuated, had no hallucinations/delusions, behaviors, and was independent with ambulation without an assistive device.Review of the most recent BIMS exam dated 9/23/25, R801 had scored a 9/15 which indicated moderate cognitive impairment.Further review of R801's documentation included a progress note created on 9/21/25 at 2:29 AM for 9/20/25 at 5:30 PM by Nurse 'B' that read, Writer witnessed resident assault a female resident with a closed fist.On 10/7/25 at 10:00 AM, R802 was observed lying in bed. R802 was asked if her jaw hurt. R802 explained, while touching her jaw on the right side, her jaw used to hurt a lot, but it was not as bad now. R802 was asked if she knew what happened to her jaw. R802 explained she thought she broke it falling.Review of the clinical record revealed R802 was admitted into the facility on 5/7/25 and readmitted [DATE] with diagnoses that included: major depressive disorder, anxiety disorder and fracture of coronoid process of right mandible. According to a Brief Interview for Mental Status (BIMS) exam dated 9/23/25, R802 scored 8/15 indicating moderately impaired cognition.Review of R802's Comprehensive Care Plan revealed an additional Focus that read, Resident is/has potential to be physically aggressive with residents in facility created 10/6/25.Review of R802's progress notes revealed multiple entries from nursing staff since May 2025 that documented R802 had a history of combative/aggressive/intrusive behaviors which included: being more agitated, aggressive, frustrated with other residents, including swatting motions for another resident to get out of their personal space, going into and out of other resident rooms, rummaging through roommate's belongings, and being combative and verbally aggressive with staff.An Event note dated 9/20/25 at 5:27 PM read in part, Writer witnessed (female) resident assaulted by (male) resident with a closed fist. Police contacted. Resident is complaining of facial pain 9/10 with signs of erythema [redness]. Ordered for x-ray.A General Progress note dated 9/21/25 at 12:24 AM read in part, Resident transferred to [hospital]. for follow up care and diagnostic testing (x-ray) related to injury/assault. Resident reports pain right side of face.Further review of the facility's investigation file included: .The investigation ascertained that physical contact did occur between the two residents, but the facility is unable to clearly extract the events leading up to [R801] striking [R802] - it does appear contact from both parties occurred, initiated by [R802]. The reaction appears to be a situational event, related to the resident's cognitive impairments.[R802] did sustain a non-displaced mandible fracture.A written statement from Nurse 'B' dated 9/20/25 at 7:30 PM read:

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 263088. Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for three (R801, R802 and R803) of three residents reviewed for abuse. Findings include:R801 and R802Review of the documentation submitted to the State Agency on 9/21/25 included an incident summary of a resident to resident physical altercation which read, On 9/20/25 at approximately 5:50pm Nurse was at medication cart in the hallway. She heard a commotion and when she turned around she observed [R801] make contact with [R802] in the face with a closed hand.Staff completed a skin and pain assessment on [R802] with notation of slight redness, res (resident) did not resent with any pain. It should be noted that the information submitted as above did not accurately represent the extent of the events that were documented on witness statements and included in the electronic medical record (EMR). Additionally, review of a nursing progress note created on 9/21/25 at 2:29 AM for 9/20/25 at 5:30 PM by Nurse 'B' read, Writer witnessed resident assault a female resident with a closed fist. Writer reported incident to physician, legal guardian and on call nursing supervisor.Police contacted.Review of the facility's submission documentation in the State Agency's abuse reporting portal identified the initial incident was not reported by the Administrator until 9/21/25 at 12:31 AM (approximately seven hours after the incident occurred).Review of the clinical record for R801 revealed the resident was initially admitted into the facility on 5/1/18 with diagnoses that included: unspecified dementia, unspecified severity, with other behavioral disturbance, undifferentiated schizophrenia, cognitive communication deficit, dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance, and adjustment disorder with anxiety. According to the Minimum Data Set (MDS) assessment dated [DATE], R801 had no communication concerns, had severely impaired cognition (scored three out of 15 on the Brief Interview for Mental Status/BIMS exam), had disorganized thinking which fluctuated, had no hallucinations/delusions, behaviors, and was independent with ambulation without an assistive device. Review of the clinical record revealed R802 was admitted into the facility on 5/7/25 and readmitted [DATE] with diagnoses that included: major depressive disorder, anxiety disorder and fracture of coronoid process of right mandible. According to a BIMS exam dated 9/23/25, R802 scored 8/15 which indicated moderately impaired cognition. R802 & R803Review of documentation submitted to the State Agency on 10/5/25 included a resident to resident physical altercation on 10/5/25 at approximately 4:30 PM which documented, in part .Risk Manager [Administrator's Name] was made aware that resident [R802] may have pushed resident [R803] subsequently causing her to fall to the floor.a bruise and swelling were noticed to right eye . It should be noted that the information submitted as above did not accurately represent the extent of the events that were documented on witness statements and included in the electronic medical record (EMR).Review of the facility's investigation into a resident to resident abuse incident on 10/5/25 documented, in part: .On 10/5/2025 at approx (approximately) 430pm Risk Manager [Administrator's name] was made aware that resident [R802] may have pushed resident [R803] subsequently causing her to fall to the floor.a bruise and swelling were noticed to right eye.Review of the clinical record revealed R803 was initially admitted into the facility on 5/14/20 and readmitted on [DATE] with diagnoses that included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, generalized anxiety disorder, age-related osteoporosis without current pathological fracture, mood disorder due to known physiological condition with manic features, dysthymic disorder, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, aphasia, senile degeneration of brain, not elsewhere classified, unspecified abnormalities of gait and mobility, delusional disorders, and major depressive disorder recurrent, moderate.Further review of the progress notes included:An entry on 10/5/25 at 6:29 PM by the Director of Nursing (DON) read: Resident had witnessed fall at the nurses station in the hallway during res to res. Resident [R802] pushed resident [R803] causing resident to fall and hit the right side of the head and right side of face near eyebrow. Resident fell to the floor. Resident [R802] began to attempt to kick and run into her while resident was attempting to stand back up.On 10/7/25 at 12:24 PM, a phone interview was conducted with Nurse 'B' (who was involved in both incidents between R801/R802 and R802/R803). When asked to recall the events on 9/26/25 between R801 and R802, Nurse 'B' reported, Was doing my med pass and had my back turned and when I turned around I saw a CNA