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 02/25/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. This citation relates to Intake #2736914. Based on observation, interview, and record review, the facility failed to provide a comfortable homelike environment with consistent availability of bath linens and laundry for residents (R102, R105, R112, R114 and R118) to ensure resident cleanliness and ability to complete personal bathing and hygiene, with the potential to affect the facility residents who used facility bath linens. Findings include:An anonymous complaint was received by the State Agency on 2/06/26, which alleged there were not enough linens to maintain the care needs of the facility residents. On 2/23/26 at approximately 11:30 a.m., Certified Nurse Aide (CNA) C, with CNA W and CNA P present, was asked about providing residents' linens. CNA C reported they were short almost all of the time. CNA C stated, Sometimes there is no linen at the start of our shift. We have brought this to administration's attention. I have cut bath blankets and I have used a pillowcase (to clean the residents) CNA C stated the towels and washcloths were short. CNA P and CNA W concurred the facility was short on linens for bathing residents and providing personal hygiene, such as brief changes, which delayed care and showers for residents. On 2/23/26 at approximately 1:15 p.m., R112 was asked about their care. R112 responded, I don't get towels or washcloths; they (facility staff) have never offered them.I would like towels and washcloths and water. R112 explained that their family member brought in hygiene and bathing wipes, which they used to clean themselves, and they would like using water to clean themselves once in a while. On 2/23/26 at approximately 2:15 p.m., R113 was observed resting in their bed in their room with covers pulled partly over their head. Review of R113's nursing progress notes on 2/04/26 at 21:30 (8:30 p.m.) revealed R113's family member requested towels and washcloths to bathe R113. The note revealed, .Due to lack of supplies on the unit, writer went to 2N (a unit on another floor) and obtained three towels and three washcloths and delivered them to the shower room. Review of R113's nursing progress note on 2/04/26 at 21:39 (8:39 p.m.) revealed R113's family members became upset and stated they removed (R113)'s bed sheet from resident bed because she believes the bed linens are dirty and belonged to the previous resident occupying the bed who she believes had Covid-19 (viral infection). The note revealed the attending nurse denied the concern and showed R113's family members were escorted out of the facility after becoming escalated and threatening to call the government on the facility. On 2/23/26 at approximately 2:25 p.m., CNA F was asked about bathing linens. CNA F responded, The linen do be short and I don't know the system. I know the lady (laundry aide) washes and it is usually done in the morning when we first come in (the aides) and nobody stay and washes at night.We do have wipes. CNA F reported they struggled to find gloves in their size. During the interview, a male resident approached CNA F and asked for an electric razor. CNA F told them they didn't have one and said the resident had asked for the electric razor earlier in their shift. CNA F explained the male resident preferred to shave themselves, however CNA F had found two electric razors with no plugs. CNA F said the resident had not owned their own electric razor. When asked (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

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 02/25/2026
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	how the resident would be shaved, CNA F reported they would shave them with a regular razor later and clarified the resident could have shaved themselves if they had an electric razor. On 2/23/26 at 2:40 p.m., R114 was asked about their care. R114 reported they had concerns and had never been offered a way to express their concerns. R114 stated, .The towels are short and you can't take a shower and I need to take a shower twice a week. There are times I have to fight for a shower. Observations on the units of the clean utility linen supply closets on 2/23/26 revealed no washcloths and only a few towels. There were four clean linen rooms total. There were no observations of washcloths or towels in residents' rooms during resident interviews during the day. On 2/23/26 at approximately 4:42 p.m., the Housekeeping Supervisor, Staff M was asked about the shortages of washcloths, towels, and linens reported by staff and residents, and observed. Staff M indicated one laundry staff had vacated their position about a week prior, and another laundry staff broke their arm and could not work. Staff M said they had linens. Staff M acknowledged it was the laundry department's job to put clean linens in the clean utility room supply closets on the first and second floors. Staff M said they wondered if staff or residents were keeping extra supplies in residents' rooms. On 2/23/26 at approximately 5:00 p.m., the Housekeeping Supervisor, Staff M was asked if there was another storage areas for facility linens. On 2/23/26 at 5:08 p.m., another storage room on the first floor was observed with Staff M, which showed only a few sheets, gowns, and bed linens, and no towels and washcloths. On 2/23/26 at 5:15 p.m., Surveyor toured the laundry room with Staff M, who reported the towels and washcloths were being washed, and showed Surveyor clean storage bins, with washed clothing. Surveyor observed running washers which appeared to be mainly laundering sheets. It was observed there were no clean towels or washcloths in the large clean laundry bins. Surveyor asked if there was any other area in the facility which had clean washcloths and towels. On 2/23/26 at approximately 5:20 p.m., Staff M showed Surveyor a room down the hall on a closed unit which was under construction, which would not have been accessible to floor staff. The unit was dirty from construction residue, and an unlabeled room door lead to a room with many cardboard boxes which were unopened. Staff M hurriedly opened a couple boxes, which revealed washcloths and towels which were packaged and not in circulation in the facility. Staff M asked if they needed to prove to Surveyor if the rest of the boxes had washcloths and towels, and began opening two other boxes, which showed additional stacks of new additional washcloths and towels. Three packages of washcloths were observed, with 60 washcloths in each pack, per Staff M, and 8 packs of towels, which had a dozen in each pack. The room was stacked with several more boxes of washcloths and towels which they showed Surveyor. When asked why these were not in circulation Staff M had no comment and said soon after reported the facility administrator was aware. On 2/23/26 at approximately 5:25 p.m., the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware of the concerns related to limited wash cloths and towels observed in the facility, and the boxes of new washcloths and towels not in circulation. The NHA and DON accompanied Surveyor into the construction area of the building and observed the boxes of new washcloths and towels. The NHA and DON both said they were unaware these new washcloths and towels were in this room, and had only newly learned of the concerns, and planned to follow up. On 2/24/26 at 9:48 a.m., the NHA followed up regarding the shortages of linen, and the observation of new linens in the construction wing of the facility. The NHA said Staff M told them this was emergency stock and said they had laundry staff pull what was needed for residents' care after finding the extra linens. The NHA said they felt like the staff had been delivering them to residents' rooms. Surveyor shared this was not reported by staff or residents or observed. The NHA clarified it was important to have emergency supplies on hand in the event their water went out and they could not do laundry and said they (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could boil water to clean washcloths and towels in an emergency. On 2/24/26 at approximately 10:48 a.m., R118 reported they were missing dresses and pants, and said, I am always missing my pants. R118 was fully alert and oriented. R118's room was observed soon after with the NHA and Staff M, with R118's permission. A few dresses were located but no pants were found. On 2/24/26 at approximately 11:15 a.m., R102 reported there were times the aides would come in their room and told them they were completely out of washcloths and towels and said they could not change them until they found some. R102 explained then the aides had to do a scavenger hunt, which bothered them, as they had to wait to be cleaned up. R102 was asked if the aides brought washcloths, towels, or linens to their room in the mornings, and said they never brought any. R102 was alert and oriented to themselves, their surroundings, situation, and time. On 2/25/26 at approximately 10:30 a.m., R105's family member (FM) R asked to speak with Surveyor when observed on R105's hall. FM R stated, .(R105) has no laundry; his sister brought him a blanket (which was missing from laundry) and he has no blanket on his bed (observed) and he has no clothes' in his room and his clothes and grey blanket disappeared. The laundry doesn't come back since May (2026) when he got here. I fill drawers (with clothing) and say 60 to 70% of the time when they visited 1 to 3 times a week R105 had no clothing. R105 said, There have never been washcloths or towels in his room. They never bring that stuff. I bring my own washrags.There is nothing and I have checked everywhere. There has never been (any) washcloths or towels in his room since the first day he was here and I have never seen any.Most of the time he does not have a blanket. FM R said there were no clothes in his room when they arrived today around 9:00 a.m., and said there was one damp shirt and pants that was not his and smelled of urine so they let staff know it needed to be laundered. FM R said to look in R105's drawers and closet. An observation was made of R105's room with his permission, which showed no clothing in any of their drawers or both closets, as they were in a private room. R105 was observed in their wheelchair during the interview and was wearing a t-shirt and sweatpants. On 2/25/26 at approximately 11:40 a.m., R105's aide, CNA L was asked about R107's missing clothing in his room and about caring for R107. CNA L acknowledged there were no clothes in R107's room, and said FM R was upset and said they smelled or urine and threw them on the floor of R107's room in a pile so they had to go to laundry on 2/24/26. CNA L acknowledged there had been a shortage on washcloths, towels, and linens since they started their job at the facility three months prior. CNA L said they had to figure out patient care, and had to use wipes and the draw sheets, however denied residents were missing care or showers. On 2/25/26 at 1:24 p.m., the laundry aide, Staff T, was asked about the shortages of linens and possible delays in laundering residents' clothing. Staff T reported there were shortages of linens on the units and said it was mainly because of the two people we are down with (not working). Staff T said they leave at 2:00 p.m., and explained there were some CNAs who tried to help them out in laundry. Staff T stated they were washing for all three shifts and had to make sure they had linen and clothes to put on the residents. Staff T clarified there were times they were short and they did not have linen. Staff T explained when they arrived at 6:00 a.m. they started the process of washing, drying, and folding laundry. Staff T was asked about an emergency supply and said they knew of one but did not know where it was. When asked about R105, Staff T said they went through a lot of clothes (due to incontinence). When asked about R118, Staff T reported R118 always got their clothing washed. Staff T said the problem was not supply as much as not having enough staff in laundry to get the clothes up to the floors. Observations of the clean utility storage supply rooms on the first and second floors during the survey on 2/24/26 and 2/25/26 (after the concern was brought to the NHA) showed the supply rooms were stacked with ample washcloths and towels, with no additional shortages observed or reported, after the concerns were (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	brought forward. The facility was asked via email on 2/24/26 if they had a policy or process on laundering linens. The NHA responded they had no such policy or process, and provided an environmental services policy upon request, in lieu of no laundry policy. An email response was received on 2/24/26 at 11:40 a.m., which revealed, We do not have a Linen policy per say. We typically have 4 full-time staff members in laundry. We currently have 3 on staff. We have CNAs and housekeeping who stay over to help. Last week we lost 2 to personal injuries outside of the facility, so we are down to 1 current full-time laundry staff member working. According to (Staff M), We pass linen as soon as it is available throughout the day. Laundry staff come in at 6am and remove dirty items from the soiled utility rooms, fold what is in the dryers from the night prior and pass linen as soon as it is done, typically 7am. They move over what is in the washer to the dryer and start more linen. When it is dried and folded it is passed again. There is at least 1 staff member assigned to laundry at all times from 6a-10p. Signed electronically by the NHA. On 2/05/26 at 4:52 p.m., a call was returned to FM R, who was asked to clarify what happened to R105's clothing earlier. FM R reported R105 had one shirt and a pair of pants in their drawer which they believed smelled of urine, so they requested the two clothing items to be sent to laundry, and the staff cleaned R105's drawers. FM R clarified R105 had no clothes in their room when they arrived earlier on this date at about 9:00 a.m and none arrived when they were present until around 5:00 p.m. Review of the policy, Physical Environment, Environmental Services, adopted 9/08/21, revealed, To provide guidelines for those in Environmental Services to foster appropriate infection control. The policy did not include any guidance respective to laundering linens or resident's clothing. No additional policy was provided by survey exit.

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

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 This incident relates to Intake 2742599.Based on observation, interview, and record review, the facility failed to protect the residents right to be free from physical abuse when R106 punched R105 in the nose, which resulted in nasal fractures, pain, acute mental status changes, and feelings of fearfulness. Findings include: Review of a Facility-Reported Incident (FRI), dated 1/10/26, revealed R106 made contact with R105's face with a closed fist when R105 rolled over R106's toes with their wheelchair on 1/10/26 at approximately 7:03 p.m This resulted in R105's injury to R105's nose, an emergent hospital transfer, and R105 sustaining bilateral (both sides) nasal fractures. The report concluded that R105 had minimal injury and no psychosocial outcome. The incident was reported to the (County) Sheriff's Department, and residents' guardians and physician. Review of the Facility Investigation report, provided and written by the Nursing Home Administrator (NHA), revealed R105 was admitted to the facility on [DATE], with diagnoses including vascular dementia, generalized anxiety disorder, bipolar disorder (mood disorder), subarachnoid hemorrhage (brain bleed), muscle wasting and atrophy (wearing down of muscles), and malnutrition. R105 used a wheelchair for mobility. The BIMS (Brief Interview of Mental Status) showed a score of 6/15, which showed severe cognitive impairment. The report showed R106 was admitted to the facility on [DATE], with diagnoses including dementia, diabetic neuropathy, schizophrenia (a mental disorder which may cause psychosis, cognitive communication deficit, muscle weakness, and an adjustment disorder with anxiety. R106 was ambulatory without a device. The BIMS assessment showed a score of 6/15, which showed severe cognitive impairment. Review of R106's interview statement, in the investigation file, dated 1/12/26, completed with the Nursing Home Administrator (NHA) and Director of Nursing (DON), revealed R106 stated, She (R105) was rolling by, pulled on my pants. I knocked her in the face. (sic) Threw me out of control, off balance. I don't like being touched. It was noted R106 refused to sign the interview statement. On 2/23/26 at 12:30 p.m., R106 was observed walking on unit (first floor) by nurse's station. He was tall and thin, and dressed in a blue shirt and pants. R106 said hello to this surveyor. Review of the facility census showed R106 had been moved to the first floor after the resident-to-resident abuse incident, on 1/15/26, and R105 remained on the second floor. On 2/23/26 at approximately 12:35 p.m., Certified Nurse Aide (CNA) C said R106 was interviewable. On 2/23/26 at approximately 2:10 p.m., R106 was observed walking on the same unit and agreed to be interviewed in their room. On 2/23/26 at approximately 2:15 p.m., R106 was asked about any incident with another facility resident. R106 said, I punched her (R105) in the nose. (R105) ran into me in her wheelchair in the hall. I think she did it on purpose. Nothing else happened. I struck her with my fist.She (R105) made me feel angry.She called the police. They (law enforcement) did talk to me. R106 said they punched R105 because their foot hurt when she ran over it. R106 said they would leave R105 alone if he saw her again. R106 was alert and oriented to themselves and their surroundings and situation. R106 was sent out soon after the incident for psychiatric evaluation and returned to the facility. Review of R106's interview statement, in the investigation file, completed with the NHA and DON, revealed R106 stated, She (R105) was rolling by, pulled on my pants. I knocked her in the face. (sic) Threw me out of control, off balance. I don't like being touched. It was noted R106 refused to sign the statement. Review of the Accident and Incident report, dated 1/10/26 at 8:30 p.m., revealed R106 was walking down the hallway when it appeared R105 ran over R106's foot with their wheelchair. R105 screamed and hit R105 in the face with a closed fist, which resulted in R105 crying and screaming. R105 screamed, He (R106) hit me. R105 was sent to the hospital emergently after being cleaned up, neuro checks were started. R105 reportedly

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	had increased anxiety and pain 10/10, with 10 being the worst. R106 was placed on 15-minute checks and the facility did not verify abuse occurred. The report showed R106 had no pain and was moved to another room on another floor. Review of Licensed Practical Nurse (LPN) Is handwritten witness statement, dated 1/10/26, revealed, I heard (R106) after say, 'No, I meant to do it. These people are always touching me and rubbing on me. I'm tired of it.' (R106) was upstairs (on the dementia/cognitive care unit) at the time. Review of Certified Nurse Aide (CNA) Ys handwritten written statement revealed, (R105) rolled towards (R106) in their wheelchair, and I think over (R106's) foot and (R106) came around the back from (R105), leaning against the wall of elevator and punched (R105) in her nose and proceeded to walk to his room. (R105's) nose started gushing blood. On 2/24/26 at 11:55 a.m., R105 was observed at the nurse's station, well-dressed and smaller statured, in a manual wheelchair. No bruising was observed. R105 agreed to be interviewed in their room. On 2/25/26 at 12:00 p.m., R105 was asked how they were doing and if they had any concerns. R105 stated, One man (R106).We had a war and I thought he was my friend. He was real nice before. I wondered what was in his pocket. I liked the color blue. and said she reached for (R106's) pocket when he hit her. R105 said, .We had quite a boxing match.I tried to pull something out of his pocket. R105 said she was injured and pointed to her face. R105 said she had hemorrhages and started crying. R105 said R106 just giggled about the incident and it made her feel terrible, as he went in for her nose and face. R105 said, How does it look now? and said she had bruising and tried to cover it up with make-up at the time. R105 said she had pain in their ears when it happened and still had ear pain sometimes and said it made her feel horrible. R105 stated, My head was spinning. My head hurts still. When asked if she felt safe, R105 said, No. I told my girlfriend I didn't feel safe here, and said she wanted to go home. R106 said they felt better now that R106 was not there (on their floor). R105 was able to tell time, and said, It's ten after 12 (which was accurate). and knew the year. R106 was oriented to themselves, time, and place, as they knew the address number and city, although at times their speech was tangential during the interview. On 2/24/26 at approximately 12:40 p.m., it was reported to the Director of Nursing (DON) R105 expressed not feeling safe in the facility, and R105 said they were still having some pain in their head and ears after the incident. On 2/24/26 at 2:00 p.m., CNA U was asked what happened during the incident between R106 and R105 on 1/10/26. CNA U confirmed they were working when the incident occurred. CNA U observed R106 hit R105 in the nose when R105 was trying to turn around from the elevator and described R105 accidently ran over R106's foot, and R106 turned around and said 'ouch'. Then said R106 hit R105 with a closed fist; it was one punch, and R105's nose started bleeding and she was crying. Then one of the nurses intervened and applied pressure to stop the bleeding and called the ambulance. CNA U said this was the second time R106 hit somebody, so they believed it was intentional, as this happened with another female resident. Review of R106's progress notes revealed another resident-to-resident incident between themselves and an unnamed female resident which occurred on 9/20/25 at 17:30 (5:30 p.m.). The progress note revealed, Writer witnessed resident assault a female resident with a closed fist.Police contacted. 15-minute checks conducted for 48 hours by nurse supervisor . Review of R106's nursing progress note dated 1/10/26 at 21:24 (9:24 p.m.) revealed, At approximately 1915 (7:15 p.m.), writer was informed by another nurse that resident (R105) had been physically assaulted by another resident (R106) and was punched in the nose with a closed fist. The assaulted resident (R105) did not lose consciousness during the attack; however, resident (R105) is a poor historian as baseline mental status is pleasantly confused, (R105) presented with active nasal bleeding. (R105) allowed writer to assist with hygiene, which including cleaning blood from face, hands and changing of undershirt and sweater but resident (R105) appeared visibly anxious and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	refused vital signs. Resident left facility via stretcher accompanied by ambulance personnel and was transported to (Name of) hospital. Police were notified.(R105) stable at time of transfer. Review of R105's progress note, dated 1/13/26 at 10:56 a.m., showed R105 fell in her room due to agitation, and could not recall what occurred clearly. Review of R105's pain log, under vitals, revealed R105's pain was 10/10 after the incident at 20:12 (8:12 p.m.) and 20:09 (8:09 p.m.), requiring two additional doses of Tylenol (as needed dosing). Review of R105's Care Plan, accessed 2/25/26, showed no updates for R105, to protect them or address their psychosocial concerns after the incident. Review of R105's physician note, dated 1/12/2026, revealed, Progress note.Full Scope of treatment. admitted to hospice. The patient (R105) was recently hospitalized for a short time and returned from the emergency room the same day. She is currently experiencing what appears to be another episode of delusions. On January 10, 2026, the patient accidentally rolled over another residents' foot while in her wheelchair. That resident (R106) screamed and hit the patient in the nose with a closed fist, causing bleeding. Following the incident, the patient was taken to the hospital where she underwent a CT scan of the maxillary (nose sinus area). The patient currently has a small bruise on the left side of the bridge of her nose. There is not more bleeding noted at this time. However, the patient is currently refusing care and is agitated, having conversations with herself. She is currently on hospital care and has multiple medications including trazadone, melatonin, Depakote, carbamazepine, Ability, morphine, lorazepam, and haloperidol among others.Diagnosis and Assessment: Nose fracture. R105's physician note further revealed: .Assessment and Plan: (R105) is a patient with bipolar disorder and dementia presenting with delusional thoughts about bruises, room cleanliness and people taking her belongings, following a recent hospitalization for nasal fracture sustained form being stuck by another resident. 1. Acute psychotic episode with delusions. Assessment: (R105) is experiencing another episode of delusions, presenting with paranoid thoughts about bruises,.about room cleanliness, maintenance issues, fears of being locked in her room, and beliefs that people are taking her clothes. This presents an acute exacerbation of her underlying psychiatric condition in the setting of recent hospitalization and trauma. Patient is currently refusing care and agitated, having conversations with herself, indicating active psychosis requiring immediate attention. Plan: Continue current psychiatric medications.Discuss with nursing supervisor regarding current episode and care management.Recent nasal bone fractures.Small bruise remains visible on the left side of the bridge of her nose, but bleeding has resolved. Plan. Monitor healing process. Continue acetaminophen (OTC Tylenol pain medication) and morphine for pain management. May need ENT (specialist consult) if patient started complaining of symptoms or recurrent bleeding.Multiple chronic conditions. Assessment.Patient has multiple comorbidities. She is currently on hospice care, indicating advanced illness with focus on comfort measures. Review of a police report from the (Name of County) Sheriff's Department, dated 1/10/26 at 19:07 (7:07 p.m.), revealed the facility called 911, and the dispatched offense was 1313 Assault Battery/Simple, and the verified (conclusion) offense was 1313 Assault/Battery/Simple.with an Exceptional Clearance date in red, stating, Victim refused to cooperate. Further review of the report revealed the Officer was unable to interview R105 due to her mental status when the incident occurred so they called R105's guardian. The Officer interviewed R106, who confirmed he punched R105 one time with his right fist when she grabbed onto his pant leg. The report verified the incident was witnessed by a facility nurse, who confirmed R105 was struck by R106 in the face with his right fist after the incident across from the elevator. The report further revealed on 1/22/26 law enforcement was able to reach R105's guardian, who declined to press charges, so the case was closed due to lack of cooperation from the victim/guardian. The Police report verified an assault occurred by R106 towards (continued on next page)

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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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R105. Review of the concerns related to the resident-to-resident physical abuse and psychosocial outcome on 2/25/26 was reviewed with the NHA and DON during the survey and at survey exit, and with Regional Nurse Consultant, Registered Nurse (RN) A. RN A confirmed the facility had addressed the concerns in their Quality Assurance and Performance Improvement (QAPI) review on 2/24/26 and had begun to implement prevention measure for other resident-to-resident incidents. RN confirmed the facility had relocated R106 to another floor in the facility after the incident occurred, which was observed during the survey. The NHA and DON had no additional comment related to the findings of abuse. Review of the policy, Abuse and Neglect, updated 6/18/25, revealed, Policy: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse,.neglect, or mistreatment.The facility follows federal guidelines dedicated to prevention of abuse and timely and thorough investigation of allegations.Definitions of Abuse, Neglect, Mistreatment, and Abuse Coordinator. Abuse: Abuse defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental 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.Types of Abuse and Examples: Physical: Physical abuse includes but is not limited to infliction of injury that occur other than by accidental means. Example: hitting, slapping, kicking, squeezing, pinching, punching, poking, twisting, roughly handling.Any person may potentially harm a resident. Potential aggressors include but are not limited to, facility staff, other residents, state employees, family members, guardian, and other visitors.If abuse is suspected, the facility will 1. Take immediate steps to assure the protection of the resident(s). This may include separation from the alleged abuse and/or provision of medical care.9. The facility will revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. This citation relates to Intake 2736914Based on observation, interview, and record review, the facility failed to provide ensure residents' activities of daily living (adl care) were completed timely for five Residents (R102, R107, R112, R115, and R116) of six residents reviewed for adl care provision. Findings include: An anonymous complaint was received on 2/06/26 by the State Agency, which alleged short staffing, residents were sitting in wet or soiled briefs for extended periods, including R102, and staff were sleeping on the night shift, neglecting resident's basic care needs. On 2/23/26 at approximately 11:35 a.m., Certified Nurse Aide (CNA) C, CNA W and CNA P were asked about staffing and resident care. The CNAs collectively reported they were unable to give residents the care they needed when the facility was short staffed, especially when there were two aides instead of three aides scheduled in their areas. They said with two aides they struggled to feed all the residents, which caused the food to be cold. They expressed the biggest concern was on the midnight shift, as some residents were supposed to be gotten up for the day by the night shift aides. They collectively said it was difficult when they had 15 to 16 residents a piece (to provide care in the daytime) and said the second floor had nearly every resident who required a check and change (every two hours) at night, and said residents were getting left wet. All confirmed they worked on both floors, and said the aides were scheduled and worked eight-hour shifts, along with the nurse. All said they were responsible for showers as well and had many residents who used lifts. All said the residents upstairs were up nearly all night, as many did not sleep and had behaviors, so they needed at least 3 aides on those shifts. The aides said there were 38 residents on the first floor on this date, as a couple residents were in the hospital, and said that each floor (1st and second floor) had about 40 residents each, with an average census of 80 residents.Review of a list provided by Unit Manager D showed 22 residents used a lift. Review of staff schedules, provided by the Nursing Home Administrator (NHA), from 2/01/26 through 2/23/26, revealed there were two aides on a floor on the following dates on the midnight shift: 2/01/26, 2/06/26, 2/09/26 (second floor), 2/11/26, 2/12/26 (second floor), 2/15/26, 2/17/26, 2/22/26, and 2/23/26. The census upon entry was 83 residents. On 2/23/26 at approximately 1:15 p.m., R112 reported when they turned their call light on to be changed, sometimes they waited 1-2 hours for assistance to change their brief. This made them feel frustrated, as they were dependent for assistance and bedbound. R112 was alert and oriented to themselves, place, time, and situation. On 2/23/26 at approximately 3:45 p.m., two interviewable residents, R115 and R116, asked to meet with Surveyor regarding care concerns. Both were observed dressed and propelled their manual wheelchairs to their room for the interview. On 2/23/26 at approximately 3:48 p.m., R115 said sometimes they needed help with transfers and toileting as they were wearing an orthopedic boot on their right foot which was casted. R115 reported they sometimes waited an hour or longer, which was upsetting to them. R116 reported they were waiting the same amount of time. R115 said, It is usually waiting in bed, and I am waiting a good hour sometimes or longer; sometimes it is for ice water, sometimes for bathroom. Sometimes for meds. R115 said they felt angry and anxious. R115 added they sometimes had to wait over an hour for Xanax (for anxiety) and added, It happened yesterday. Yesterday evening, I waited about an hour and a half. This one (time) was for picking up my dinner tray and for ice. R115 said they went to the Administrator about their concerns. R116 said they had similar wait times when they needed water or medications, and they felt upset and anxious when this happened. Both residents were alert and oriented to themselves, situation, place, and time. An observation was done during the interview of R115's and R116's call light, which visually activated (lit up) in the hallway when R115 pressed their call light. On 2/24/26 at approximately 11:15 a.m., R102 was (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed in their room, in a bariatric bed reading a book. R102 agreed to be interviewed, and explained they were in bed frequently and were dependent upon staff for care. R102 stated, It takes two hours for the call light to be answered. They (staff) shut the light off and tell you they are coming back. Certain aides tell you they are busy. I got told I go to the bathroom (need to be changed) too much. I am on Lasix (a water pill which can increase urination) and some say, 'You didn't pee enough to call it wet,' and I say, 'I am wet and I need to be changed. R102 clarified, They (staff) are doing a terrible job of answering call lights, more in the afternoons. I am realistic. When it gets to be an hour, I get upset. During mealtimes there are times when you don't ask for anything. R102 was asked about the complaint allegation about being left wet several hours. R102 stated, I had a midnight aide and she pulled out 11 wipes and she did wipe me, but my butt (bottom) wasn't clean. R102 had to wait to be changed until the morning, and said she had hard, caked-on stool by the morning. R112 said it made her feel awful to wait so long. On 2/25/26 at approximately 10:40 a.m., R107's Family Member (FM) R reported when they visited, they found R107 soaked this morning when they arrived and found them soaked wet often during their visits. R107 was present during the interview and made gestures pointing to their brief and nodded rapidly, appearing frustrated. FM R confirmed this was upsetting to R107, and to them when they found them soaked. Surveyor asked R107 yes/no questions and for R107 to identify ten objects in the room, which they did accurately by pointing. It appeared R107 had the ability to convey some basic information and needs, which FM R confirmed. Concerns regarding residents adl care not being completed timely and staffing concerns were shared with the NHA, the DON, and Regional Nurse Consultant, Registered Nurse (RN) A at exit. There was no additional comment regarding the concerns. Review of the policy, Administration: Staffing, adopted 07/11/2018, revealed, Our facility provides adequate staffing to meet needed care and services for our resident population. Procedures: 1. Our facility maintains adequate staffing on each shift to ensure that our residents' needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are adequately staffed to ensure that resident needs are met. 2. Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. This citation relates to Intake 2733234 Based on observation, interview, and record review, the facility failed to provide consistent meaningful person-centered activities for two Residents (R101 and R114) of three residents reviewed for activities. Findings include: A complaint was received to the State Agency on 2/03/26, which alleged activity concerns. On 2/23/26 at 1:29 p.m., R101 was observed in their room, seated in their wheelchair. A current monthly activity calendar was observed posted in their room. On 2/23/26 at 1:30 p.m., R101 reported the Activity Director posted the monthly activity calendars but was not following the calendar. R101 said they were missing activities, especially on the weekends, such as BINGO, and brain games. R101 added the activity staff never did room visits. R101 also felt the music activities did not represent their preferences. R101 reported they were usually not being taken on outings when the residents went into the community. R101 clarified this was upsetting to them. R101 wheeled over to their activity calendar and showed Surveyor most of the weekend activities were not occurring, such as when they tried to attend Brain Games this past Saturday and they waited, and no one came (to the day/activity room). R101 said they were bored on the weekends and would attend activities on the weekends if they were consistently offered. R101 explained they were not notified when an activity was cancelled or a time was changed, which caused them to feel frustrated and upset. On 2/23/26 at approximately 2:00 p.m., the Nursing Home Administrator (NHA) was asked about R101's concerns with missing activities. The NHA confirmed some activities were getting missed currently because of low staffing. The NHA explained they had hired a part-time staff who they needed to let go and another new hire stopped coming to work so they were currently hiring, onboarding and training new staff. The NHA explained their COVID outbreak impacted their activity program as well, and said they cancelled one of the community store outings due to the outbreak. An observation of the first-floor activity calendar for February 2026 in R101's room revealed the activity Brain Games was scheduled on Saturday, 2/21/26 at 3:00 p.m The calendar did not appear to show any scheduled community outings. On 2/23/26 at 2:30 p.m., the first-floor activity calendar was observed posted in the day (dining) room. The calendar showed BINGO was scheduled on this date at 2:30 p.m. On 2/23/26 at 2:35 p.m., the first-floor day (dining/activity) room was observed (where group activities were held) and showed no BINGO activity. It was noted that R114 was seated in their wheelchair in the dining room at a table, with a few other residents present and no staff. On 2/23/26 at beginning at 2:40 p.m., R114 was interviewed in the first-floor day room. R114 said they were waiting for BINGO to start and had been there a few minutes. R114 said the activity staff were always late for activities, and said the activities did not start on time, which was frustrating to them. R114 said, Everything is late. The BINGO is supposed to start at 2:30 p.m., and at a quarter til (2:45 p.m.), they (activity staff) might stroll in. R114 said they were missing activities, and clarified there were no activities on Sundays and some Saturdays. Now we play BINGO on Mondays only. R114 said they used to play BINGO three times a week. R114 clarified everyone (residents) liked BINGO and felt they should at least have BINGO regularly at a minimum. R114 was alert and oriented to themselves, time, place, and situation, and could tell time accurately during the interview. Review of the first-floor activity calendar showed a full day of scheduled activities on Sundays, and BINGO was only noted on Mondays, although a BINGO pass was noted on two of four Saturdays. On 2/23/26 at 3:10 p.m., R114 was observed leaving the first-floor day room, saying they had waited long enough (40 minutes). At least three other residents had left the dining room. On 2/23/26 at 2:35 p.m. through 3:15p.m. (40 minutes) it was observed no activity staff or BINGO activity was observed in first floor day room. On 2/23/26 at 3:27 p.m., BINGO was observed to have just started in the first-floor day room, with the first BINGO number called by an activity aide (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at that time. There were eight residents present, with five residents playing BINGO, including R114, who returned. On 2/23/26 at approximately 3:43 p.m., the Activity Director, Staff B was asked why there was no BINGO today per the activity calendar in the first-floor dining room at 2:30 p.m Staff B was made aware R114 was waiting for BINGO for at least 40 minutes, which frustrated them. Staff B acknowledged BINGO had started late. Staff B explained the facility was hiring more activity staff and said it was just themselves and one other full time activity staff on this date, who were covering activities on both floors (the first and second floor). Staff B said the activity was running late upstairs, and explained they were bouncing between floors and doing some charting and said, That's my fault. Staff B said there was a no call, no show today (an activity aide called off), and said it took longer for the staff to clean the activity room upstairs before they could start their activity earlier upstairs (second floor), which subsequently made them late for the first-floor activity, BINGO. Staff B was asked how many activity staff were in the building, and they said it was themselves and a new activity staff member recently hired. Staff B understood the concern related to R114 waiting for BINGO, feeling frustrated, and leaving. It was shared R114 was not aware BINGO was running late, as Surveyor was with R114 during the duration of their waiting, which Staff B acknowledged. Staff B said the calendar showed subject to change but understood the residents' perception and the concern may have been counting on activities at scheduled times, unless notified prior. On 2/24/26 at 10:00 a.m., the activity calendar showed a light exercise activity was scheduled to start on the second floor at 10:00 a.m. On 2/24/26 at 10:21 a.m , the second-floor day (dining/activity) room was observed. There was no activity or residents in the dining room (they were in the hallway) as the dining room was being thoroughly cleaned by multiple housekeeping staff. A few minutes later, an activity was observed to begin. On 2/25/26 at 9:35 a.m., the Activity Director, Staff B was interviewed in full about activity concerns reported by R101 and R114. Staff B said they had COVID during the past few months and said this caused some shifts in the activities offered. Staff B explained this affected the whole first floor so there were no group activities for an extended period. Staff B acknowledged there were some late and missed activities for both residents and said they (facility) were hiring more staff. Staff B said the activities calendar noted the activities were subject to change when Surveyor shared both R101 and R114's self-reported they were not made aware when activities were moved or cancelled. Surveyor noted there were no activities documented in the EMR (electronic medical record) for both residents. Staff B said they used their own logging of activities in a separate system. It was shared that the Nursing Home Administrator (NHA) earlier told Surveyor their expectation would have been the activity staff would transfer their documentation into the EMR. Staff C explained activities were getting missed more on the first floor (verses the second floor) as residents were more independent, which included R101 and R114. Staff C clarified they spent more time completing activities on the second floor with the (primary) dementia or cognitively impaired residents who had some behaviors. During the interview, Surveyor viewed R101's and R114's February 2026 activity documentation logs with Staff C. The logs showed for the past month (look-back period) they each participated in activities about 64% and 56% days (2/01 through 2/23/26) offered, respectively. It was noted there were similar dates when both had no activities, showing activities may not have been offered on those days. The logs also showed there were no refusals documented. The logs also showed no activities were documented on Sundays, other than two dates of four when residents received their coffee and a newsletter. Staff C understood the concerns and said they would start documenting refusals. Staff C explained they have additional staff incoming. Further review of the activity calendar with Staff C revealed there were activities scheduled on the same times on both floors simultaneously. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted when both or all activity staff were observed in activities, as occurred during the survey, it would not be possible to have both scheduled activities covered or ongoing on both floors at the same time. Staff C planned to address this as well. Staff C acknowledged they could use more training with dementia residents and was pursuing additional training to maximize activity engagement for the residents especially with behaviors related to cognitive deficits on the second floor. The NHA was made aware of these concerns during the survey and acknowledged more staff were incoming related to activity delays and or missed activities. The NHA noted the calendar concerns and activities being subject to change noted on the calendar. Surveyor shared the residents self-reported counting on activities at scheduled times unless otherwise informed. Review of an email received from the Director of Nursing (DON) on 2/25/26 at 10:40 a.m. revealed, Covid outbreak started on 1/26/26 last positive was on 2/1/2026. This showed the facility COVID outbreak lasted one week, per this email.Review of the policy, Activities: Resident's choice, adopted 8/01/2019, revealed, It is the policy of this facility that residents shall have the right to participate or not participate in leisure, recreation and social involvement of their choosing. PROCEDURES: Residents will be invited and encouraged to assist in the planning and development of the recreation programming.Residents will be informed of activities of preference and interest and programs through:Posted calendarPosted announcementsIndividual communicationIndividual care planResidents will be invited to attend activities and will be provided the opportunity to participate in structured and individual programs.Preferences for residents who have Dementia will be determined through communication with the resident, family, friends and care givers.Assistance will be provided for residents who wish to participate but are not able to get to activities on their own. Residents who prefer not to participate in structured programs will be offered alternatives and necessary support/resources for meaningful individual pursuit of leisure interest.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 relates to Intakes 2730741, 2706499, and 2706385.Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent four resident-to-resident altercations for R109 and R108, R104 and R117, R103 and R110, and R103 and R111 of four incidents reviewed. Findings include:R109 and R108:Review of a Facility-Reported Incident (FRI), received on 1/02/26 at 4:28 p.m., to the State Agency, revealed on 1/02/26 at approximately 3:50 p.m., Licensed Practical Nurse (LPN) V heard R109 say, Get the f*ck out of my room, b*tch, and upon reaching the doorway, R108 reported R109 had been swinging at them. Then LPN V observed R109 kicked R108 on his back, who was on the floor in R109's room. The residents were separated. R109 had a scratch on his neck and R108 had a cut on their left upper arm. The report alleged a physical resident-to-resident interaction with no psychosocial outcomes or significant injuries.Further review of the FRI report revealed R109 was admitted to the facility on [DATE], with diagnoses including mild dementia, psychotic disturbance, mood disturbance, schizoaffective disorder (mood disorder with possible psychotic features), anxiety, traumatic brain injury, and intellectual disabilities. R109 had a score of 8/15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated severe cognitive impairment.Further review of the FRI report revealed R108 was admitted to the facility on [DATE], with diagnoses including stroke, bipolar (mood) disorder, schizophrenia (disorder which may cause psychosis), PTSD (Post-Traumatic Stress Disorder) and anxiety, with a BIMS score of 12/15, which showed mild cognitive impairment. R108 reportedly refused a full assessment and said they had nothing wrong with them. Both residents had a history of aggression towards other residents and during care. R108's interview showed he went to talk to R109 about a car and R109 swung at them. When asked if they were kicked, R108 said, I don't know. When R109 was asked about the incident, he stated, I was sleeping when he (R108) came in here and attacked me again, when I was sleeping. He fell on top of me; I hit my head. He (R108) slammed me to the ground and punched my forehead (this part of R109's reporting was not witnessed). R108 was placed on 15 -minute checks to not go back to R109's room. A stop sign was placed on R109's door. The residents/guardians declined the police to be contacted. The facility concluded that a resident-to-resident incident occurred between R109 and R108 however it could not be concluded what happened before staff observed R109 kick R108, and they did not substantiate abuse or neglect. The report further revealed that R109's Traumatic Brain Injury (TBI) contributed to lack of impulse control or understanding consequences and said R108's dementia caused him to not be able to be act intentionally or purposely. It was noted R108's BIMS score was 12/15, which showed only moderate cognitive impairment, and the report showed mild dementia.On 2/23/26 at 3:35 p.m., R109 was observed in their room, dressing and laying on their bed. R109 sat up on the edge of their bed and agreed to be interviewed. There was a Velcro stop sign observed on their room door. On 2/23/26 at 3:37 p.m., when asked if they had any concerns or incidents with other residents, R109 said, I don't want to talk about that, and walked out of their room. No further interview was attempted. On 2/24/26 at 10:34 a.m., R108 was in their room, dressed and seated on their bed, with no bruising or skin concerns observed. R108 was asked if they could be interviewed. R108 declined via gesture as they were listening to a radio program. On 2/25/26 at 9:32 a.m., R108 was in their bed, and when asked how they were doing or if they had any concerns, R108 gave a thumbs up, indicating they were doing fine. When asked if they could be interviewed, they said, No. On 2/25/26 at approximately 9:40 a.m., R108's nursing staff were asked how they communicated. It was confirmed that R108 could talk when they wanted to speak and could communicate their basic needs. On 2/25/26 at 3:57 p.m., Licensed Practical Nurse (LPN) V (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was asked about the resident-to-resident incident between R109 and R108 in a phone interview. LPN V confirmed they were working and witnessed the incident occurred. LPN V stated they heard R109 tell R108 to get out of their room and saw R108 on the floor of their room. LPN V stated themselves and a nurse aide were trying to help R108 get off the floor when they saw R109 kicking R108 in the back and attempted to kick them more. R109 kicked R108 twice on their left side on their left shoulder or back. LPN V said R109 and R108 had prior altercations and R109 did not want R108 in their room. LPN V said R108 came into R109's room to talk to R109 about a car. After being kicked, R108 had back pain and a small cut to their arm, and R108 had scratches on their neck. LPN V said R109 said they got in a fight before they got there. LPN V reported R108 asked for pain medication, which was provided for back pain, and R109 did not complain of any pain. When asked if the incident was intentional, LPN V said, Yes, (R109) was adamant he wanted (R108) out of his room.(R109) said, ‘Get him out of this room; (R108) is not supposed to be here.' Review of R109 and R108's resident-to-resident investigation report revealed LPN V witnessed the incident, as described in their witness statement. The residents were moved to different floors after the incident, and no other incident occurred. Review of a psychiatry visit dated 1/06/26 showed R109 was being seen for follow up related to behaviors. Further review revealed another resident-to-resident incident occurred on 7/10/26, when R109 hit another resident who was sent to the emergency room and returned on 7/11/25 with medication adjustments. Review of R108's Interdisciplinary team note revealed, .Based on the findings, review of the clinical record, and interview with the staff, a decisive conclusion was made that this resident (R108) was struck by other resident (R109).The facility is unable to clearly extract events lead to the occurrence but physical contact was witness (sic) between the residents involved.15 minute checks were completed with no deviation from baseline.Care plan will be updated. Review of R108's nursing progress note, dated 1/06/26, showed Room move completed. Guardian made aware. No other concerns or issues. Review of R108's provider notes, dated 1/05/26, showed R108 had no increased pain or injuries after the incident. R104 and R117 Review of a FRI received on 2/25/26 (during the survey) revealed, .Incident Detail:At approximately 5:00 pm on 2/17/26, Resident (R117) came into the hallway from her room which she was sharing with resident (R104) at the time, loudly saying, She hit me. Staff responded and kept the residents separated. Skin assessments and pain assessments were completed. No injuries were noted. Administrator, Director of Nursing (DON), Physicians, and legal guardians were notified. The report further revealed R104 denied hitting R117 when they got their bathrobe back, and said physical contact was not verified.On 2/24/26 at 12:50 p.m. R104 was observed in their room and agreed to be interviewed at their door. R104 was thin in stature, and had long hair, which appeared unwashed, and was wearing a gown with a covering. On 2/24/26 at 12:52 p.m., R104 was asked about any concerns or incidents, and denied any concerns or incidents with facility residents. R104 was oriented to themselves and their surroundings. On 2/24/25 at 2:15 p.m., the Nursing Home Administrator (NHA) reported they had just submitted a 5-day investigation into a recent incident a few days prior between R104 and R117 when they were roommates. The NHA described R117 said R104 hit them with their housecoat, when R104 said R117 had their clothes and denied hitting R117. The NHA said there was no outcome/injury, and abuse was unsubstantiated. On 2/25/26 at approximately 8:45 a.m., R117 was observed on the unit walking with a cup of coffee in their hands. R117 was wearing a pink shirt, and a headband. R117 was oriented to themselves, place, situation and time, as they could read a clock. They were unavailable for an interview but said to come back when staff were not with their roommate. On 2/25/26 at 9:19 a.m., R117 was asked if they had any concerns. R117 said, (R104) hit me. R117 said, One of the girls here gave me (R104)'s pajamas on accident. as R104 was in their joint room at the time. (continued on next page)

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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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R117 explained, (R104) hit me with the bathrobe. She was not wearing it and it was not hard. (R104) was carrying the bathrobe across her chest. It didn't hurt. R117 said they had no bruises, and staff checked. R104 was asked if they felt safe. R117 responded, I feel safe in this (current) room but not in the other room (prior with R104). That was the first time I got switched into her (R104's) room. I am ok now. I am not scared anymore. I feel safe here. I thought they were mine (the pajamas) and I put them on. We (residents) have to be nicer and they (residents) can't hit people. She did it on purpose. Everything is ok now. R117 denied any other incidents with R104. On 2/25/26 at approximately 4:15 p.m., LPN J confirmed during a phone interview they were on shift when the incident occurred. LPN H said they had to switch R117 to R104's room per management directive, although most were aware R104 did not like having roommates and had some aggressive behaviors. LPN J reported R104 wanted their door closed and R117 liked their door opened. LPN J said they and staff had told administration they had concerns and this would not be a good fit, as R104 was aggressive and R117 was nice, and administration had agreed to switch them back (moving R117 out) in the morning. When they were roommates that afternoon, LPN J said R104 got mad at R117 and struck them. R117 came out of the room and said, (R104) hit me in the face with her hand. LPN J said R104 was wearing their bathrobe, so they did not believe or recall R117 being struck with the bathrobe, as R117 did not report that. Per LPN J, R117 was crying and very upset, and said they wanted their room changed. LPN J said there were no bruises on R117. LPN J said R117 was oriented to themselves, place and person. LPN J said they believed the incident occurred as R104 had hit the staff before, and the unit manager moved R117 out of R104's room right after the incident, to prevent any recurrence. Review of LPN's witness statement at the time of the incident corroborated the occurrence and description of the incident. Review of R117's progress notes revealed an incident occurred on 2/17/26 at 16:45 (4:45 p.m.) when R117 came out their room, appearing distressed, stating, (R104) hit me. She hit me. Nursing responded and followed the resident to her room where the resident pointed at her roommate and stated, She hit me. Staff separated the resident immediately.Resident (R117) stated to the staff, She thought I took her clothes.(Staff) was the one that brought them to me, so I gave them back to her, and she hit me with the bath robe. Immediate intervention: Room move for the resident. R103 and R110 Another third FRI was received by the State Agency on 12/19/26 which described a resident-to-resident altercation between R103 and R110 on 12/19/25 at 11:20 a.m Review of the FRI revealed R110 was observed in R103's room. R103 was observed to have a hold of R110's forearm and made contact towards R110 with his other hand. The facility concluded that the resident-to-resident interaction occurred resulting in no injury and no negative psychosocial outcome. It was described the Unit manager, LPN H, heard resident R103 yelling out, from his room. Upon reaching the doorway to the room, LPN H observed R110's feet in a laying position on the foot of the bed, however the privacy curtain was restricting the full view; the only portion of R103 that could be seen from his wheelchair striking something. Upon reaching the residents beyond the curtain, it was observed that R103 had a hold of R110's right wrist with his left hand. Staff immediately intervened and separated the residents. Both residents were assessed for injury; no visible injuries or psychosocial concerns were noted at the time of the assessments. The report showed physical contact occurred from R103 towards R110. Both R103 and R110 had marked cognitive impairment per the report. Review of the Electronical Medical Record (EMR) showed R103 had been discharged from the facility. On 2/24/26 at 1:27 p.m., R110 was observed walking ad lib in the facility hallway. R110 made poor eye contact and could not answer any questions. R110 was orientated to their name only and had no bruising or injuries noted. On 2/24/26 at approximately 1:45 p.m., R110's CNA, CNA L confirmed they were working when the resident-to-resident incident occurred between (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R103 and R110 and had cared for both residents regularly. CNA L clarified R110 was not interviewable. CNA L said R110 had a behavior of climbing into other resident's beds, and said it was impossible to stop her, so they would redirect her when this was discovered. R103 said staff intervened, R110 had no bruising, and R103 was not injured, and R110 did not recall the incident. CNA L said R103 did not like other resident's coming into his room and would yell at other residents when this occurred. CNA L confirmed the incident occurred as described per their understanding and neither resident was injured. CNA L denied R110 was abused and had no signs of being abuse. R103 and R111A fourth FRI received by the State Agency revealed a resident-to-resident physical incident occurred on 12/18/26 at 10:48 p.m., between R103 and R111. The FRI described R103 was moving about the hallway around mealtime, exclaiming that R111 stole his items, Staff intervened and separated residents, R103 (sic- went) into the dining-room, R111 was still in the hallway, R103 then re-emerged and continued his claim that R111 is a thief and approached R111 who then reacted with physical contact. Staff were unsure who made physical contact first, but the encounter was mutual, resulting in contact made to R103's left side of the face and R111's right side of the face. The report confirmed R111 and R103 hit each other and had no injuries. Both residents had marked cognitive impairment per the reports and were immediately separated. The report revealed LPN V was present and verified the physical incident occurred. On 2/25/26, concerns regarding adequate supervision and the higher number resident-to-resident incidences were shared at survey exit with the NHA, DON, and Regional Nurse Consultant, Registered Nurse A. RN A indicated the facility had addressed the concerns in their Quality Assurance Improvement Process (QAPI) during the survey. RN A described they had begun to make proactive changes in programming, supervision and care planning on their second floor, related to the care of residents with cognitive impairment, dementia, and geriatric psychiatric concerns. The NHA and DON had no additional comment. Review of the policy, Administration: Staffing, adopted 07/11/2018, revealed, Our facility provides adequate staffing to meet needed care and services for our resident population. Procedures: 1. Our facility maintains adequate staffing on each shift to ensure that our residents' needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are adequately staffed to ensure that resident needs are met. 2. Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. This citation relates to Intake 2736914. Based on observation, interview, and record review, the facility failed to ensure the availability and consistent provision of evening snacks. Findings include: On 2/23/26 at approximately 1:15 p.m., R112 was observed lying in their hospital bed. On 2/23/26 at approximately 1:17 p.m., R112 reported their family member brought them snacks, as they had never been provided or offered a snack at the facility. R112 stated, I would like to at least be offered and see if there is something I like. R112 reported they were restricted to staying in their bed in their room at that time. R112 was alert and oriented to themselves, their surroundings, situation and time.On 2/23/26 at approximately 2:40 p.m., R114 was observed seated in their manual wheelchair in the facility dining room. On 2/23/26 at approximately 2:45 p.m., R114 said they were missing snacks at times, especially in the evenings, which bothered them. R114 stated, If you are not at the desk when they pass them out, you do not get a snack. It is peanut butter and jelly (sandwiches), pudding, and sometimes chips. You have to run to that desk to get it. R114 said there were days they did not get a snack and wanted a snack daily. R114 was oriented to themselves, their surroundings, situation, and time.Review of the medical record revealed R114 was their own responsible party. On 2/24/26 at 3:30 p.m., the Dietary Manager, Staff N, was asked about snack provision and availability for the residents. Staff N reported they had a variety of snacks including chips, cookies, Jello, pudding, sandwiches, and rice crispy treats. Staff N stated they placed the snacks on a tray in the evening, which was taken to the unit. Staff N indicated they were aware of residents stealing snacks and hoarding them in their rooms, and said the nurses were aware. Staff N said they believed it was possible the snacks were being taken by staff, as they disappeared quickly. Staff N said they could have the nurses lock the snacks in the med room to ensure the residents received them and were not hoarding them in their rooms. On 2/24/26 at approximately 5:00 p.m., the Director of Nursing (DON) shared they understood the concern and would be making improvements in their snack process including assigning a CNA (Certified Nurse Aide) to pass the HS (nighttime) snacks and put them in the med room in a sealed container. The DON said the Dietary Manager was going to check that container at least three times a week and ensure they were checking the dates (such as for the sandwiches). The DON said they would review the updated process in their resident council and food committee meetings. On 2/25/26 at approximately 10:50 a.m., Family Member (FM) R was asked if R107 received snacks when requested. FM R indicated they were not aware of R107 receiving snacks, as they seemed hungry during their visits, so they had asked for double food portions for R107, which were often not received. During the interview, R107 was observed quickly propelling themselves in their manual wheelchair in and out of their room. FM R said R107 was not verbal, however could respond to yes and no questions accurately. R107 shook their head no when asked about receiving snacks. R107 showed they were hungry at night by pointing to the surveyor's stomach and then to their stomach and grimaced, appearing distressed. FM R said R107 did this when they were hungry, which they did often. When FM R was asked if they had filed a grievance or concern form, FM R indicated this had not been offered and said they would like to file a concern form. The Nursing Home Administer (NHA) was notified of their request after the interview. On 2/24/26 at approximately 12:30 p.m., the NHA and Director of Nursing (DON) arrived outside R107's room and said they had spoken to FM R who denied concerns to them with snacks. Both said R107 received enough food and indicated they would follow up with FM R with a concern form. On 2/25/26 at approximately 8:20 a.m., DM N was asked where the snacks were kept. DM N said the snacks were kept in their office. DM N (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	agreed to show surveyor their office. On 2/25/26 at approximately 8:25 a.m., Staff N's office was observed with [NAME] O present. There was adequate evidence of chips and dry snacks being available.On 2/25/26 at approximately 8:30 a.m., the concerns were reviewed with both related to residents reporting missing their snacks and snacks not being offered. Both agreed the snack provision and availability process should be improved to ensure all residents were being offered a snack and understood the concern. On 2/25/26 at approximately 6:00 p.m., the concerns were reviewed with the NHA and DON related to residents' reporting not receiving snacks. There was no additional comment. Review of the policy, Dietary Services. Bed Time (HS) Snack, adopted 7/11/2018, revealed, Policy: It is the policy of the facility that all residents be offered a midnight snack, to the extent medically possible. Purpose: To ensure resident's appetite is satisfied before bedtime.Procedure: 1. Residents on regular diets are offered a snack before bedtime each evening.3. Bedtime (H.S.) snacks must be documented, indicating the H.S. snack was offered.