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	06/16/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): 3044078 and 3044417. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for one (R804) of four residents reviewed for abuse, resulting in psychosocial harm using the reasonable person concept when R805 laid in bed with R804, exposed his genitals, and touched R804's breast. Findings include:A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed there was an allegation of sexual abuse between R805 and R804 that occurred on [DATE]. A review of a complaint submitted to the SA revealed an allegation that R804 was sexually assaulted by an unknown male resident. On [DATE], an unannounced onsite investigation was conducted. On [DATE] at approximately 8:30 AM, R805 was observed lying in bed. R805 said hello in Spanish. Certified Nursing Assistant (CNA) 'E' was observed at R805's bedside. CNA 'E' explained she was assigned to provide 1:1 supervision for R805 but was not sure why. CNA 'E' said she thought it was because R805 wandered, but was not entirely sure.On [DATE] at 11:18 AM, R804 was observed lying in bed. R804 smiled when addressed, but then did not make contact or verbally respond to any questions. A review of R805's clinical record revealed R805 was admitted into the facility on [DATE] with diagnoses that included: Parkinson's Disease and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed no assessment of R805's cognitive status. The MDS noted R805 did not have any behaviors including wandering, and required partial/moderate assistance with transfers and walking. A review of R805's Wandering Risk Scale assessments revealed on [DATE] and [DATE], R805 was assessed to be at risk to wander. A review of a General Progress Note dated [DATE] at 8:30 AM, written by Licensed Practical Nurse (LPN) 'F', revealed, writer was at medication cart when nursing aid approached cart to report (R805) in another resident's bed upon writers' arrival in room writer witnessed (R805) in the resident's bed and under the covers together writer called out for another nurse assistance previous shift (LPN 'G') approached room both nurses pulled the covers back writer seen (R805) undressed from waist down other resident was still in gown with top half down and breast exposed brief was still on person. (R805) was turned to his left up close on resident genitals exposed resident was laying straight back resident's face had beefy red discolor on their right side and face was turned to their left while body remained straight .(R805) stated he didn't know what happen, and he doesn't remember when writer asked translator to ask resident why he took his brief off resident stated it was dirty. Resident then said he had a headache rested his head back down and didn't answer any more questions .A review of R804's clinical record revealed R804 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia. A review of a MDS assessment dated [DATE] revealed R804 had severely impaired cognition. A review of a General Progress Note dated [DATE] at 8:30 AM, written by LPN 'F', revealed, writer was at medication cart when nursing aid approached cart to report a resident (R804's) bed upon writers' arrival in room writer witnessed a male resident in the (R804's) bed under the covers writer called out for another nurse assistance previous shift nurse (LPN 'G') approached room both nurses pulled the covers back writer seen male resident undressed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	from waist down (R804) was still clothed with a gown on top half of gown was down and breast exposed brief was still on. male resident was turned to his left up close on (R804) male resident genitals was exposed (R804) was laying straight on her back face had beefy red discolor on right side and face was turned to left while body remained straight . resident was transferred via EMS (emergency medical services) to (hospital) for further evaluation .A review of a IDT (Interdisciplinary Team) Progress Note dated [DATE] in R804 and R805's clinical records revealed, The interdisciplinary team reviewed the investigation findings related to the resident-to-resident sexual contact event that occurred on [DATE]. Based on staff observations, resident assessments, interviews, and reviews, the investigation verified that inappropriate sexual contact occurred between the residents. Staff observed the male resident in bed with the female resident. The male resident with his brief removed and genitalia exposed, while the female's gown was displaced upward exposing her breasts. The male resident was observed with his hand on the female's right breast. The female resident was not observed touching the male resident and was noted to be facing away from him. A reddened area was identified on the female's right cheek during the immediate assessment. Due to the female resident's severe cognitive impairment, developmental delays, BIMS (Brief Interview for mental status) score of 3 (which indicated severely impaired cognition), and legal guardian status, she lacked the capacity to provide informed consent. The event was treated as an allegation of sexual abuse .Review of clinical records, behavioral documentation, prior events, and collateral information identified no prior resident-to-resident sexual incidents involving either resident. Both residents have documented cognitive impairment, which may have contributed to impaired judgment, impaired recognition of personal boundaries, and inappropriate resident-to-resident interactions. The exact circumstances leading to the event could not be fully determined .Further review of R805's clinical record revealed the following which indicated he had a history of wandering into other resident's rooms and going into their beds:A General Progress Note dated [DATE] noted, Res (resident) urinated in his how and garbage can on 2 different times today. also observed this morning sitting at the bed of another res. Res was assisted back to his own bed.A Mood/Behavior progress note dated [DATE] noted, Resident observed lying in another resident's bed wearing wet pants. Writer attempted to redirect resident to his own room for incontinence care with CNA assistance. Resident became agitated upon redirection and began yelling in Spanish. Resident then stood up from chair and continued yelling .It was documented in a General Progress Note on [DATE] that R805 was moved to a new room on the second floor from the first floor. There was no documentation as to why the room change was made. A review of the facility's investigation into the sexual abuse incident mentioned above, revealed the following:R804 was transferred to the hospital for further evaluation to include a forensic examination as requested by her legal guardian. A summary written about R805 noted, Review of admission records and collateral information received from the resident's prior care setting identified a history of wandering and searching behaviors related to his deceased spouse .R804 was unable to meaningfully participate in an interview due to severe cognitive impairment. It was noted that LPN 'F' was interviewed and said (R804) was lying on her back facing up, (R805) was to her right, lying on his left side. I got (LPN 'G') we went into the room, when the blanket was pulled down (R804's) gown was pulled up and her right breast was exposed. Her brief was in place and intact. (R805) had his right hand on (R804's) right breast. (R805's) gown was pulled up, his brief was pushed down to his ankle and his genitals were exposed .skin assessment was done for (R804). She had a red mark to the right side of her face .It was noted that LPN 'G' was interviewed and said, .(R805's) brief was on his left ankle, his gown was pulled up, exposing his genitals. (R804's) gown was pulled up, exposing her right breast. (R804) was lying on her back, (R805) was lying to the right of her on his left side facing her .It was noted that CNA 'C' was interviewed and said, .I went into (R804's) room, the door was closed, I opened the door and called for the nurse. (LPN 'F') came to the door and we entered the room; they were under covers. (LPN 'F') pulled the blanket down and (R805) had gown on; brief was on his ankle. (R804) was lying on her back, (R805) was lying on his left side (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	on the right of her, facing her. (R804's) right breast was exposed .It was documented that .the allegation was verified based on direct staff observations .A review of hospital records for R804 revealed she received a Sexual Assault Nurse Examiner (SANE) exam. (A SANE exam is a specialized medial forensic examination to collect evidence related to sexual assault. The exam can be invasive in nature as it includes collecting bodily fluids, swabbing of the genital area, etc.)On [DATE] at 12:01 PM, an interview was conducted with CNA 'C'. When queried about what happened on [DATE] with R804 and R805, CNA 'C' reported she was reassigned to the second floor from the first floor. When she got to the unit, she checked on the residents in her set. R804's door was closed so she knocked and opened the door. When she opened the door, there was a man lying in bed with R804 and they were both underneath the blanket. CNA 'C' called for the nurse who came into the room. R804's right breast was out and R805's brief was all the way down and his genitals were exposed. CNA 'C' said R804 was just lying there on her back and R805 was lying on his side facing R804. CNA 'C' said two nurses took over from there. On [DATE] at 11:07 AM, an interview was conducted with LPN 'F' via the telephone. When queried about what happened on [DATE] with R804 and R805, LPN 'F' reported she was their assigned nurse that day. A CNA came to get her and said R805 was under the covers with R804 in her room. LPN 'F' explained she observed a beefy red cheek on R804's face, R805's brief was down to his ankle, and R804's brief was on, but her breast was exposed. According to LPN 'F', the CNA said R805 was touching R804's breast. LPN 'F' was not sure about any past behaviors of R805, sexual or wandering, but said other nurses had mentioned he was flirtatious. LPN 'F' said she heard from a CNA that R805 had went into another resident's room before to use the bathroom. On [DATE] at 1:48 PM, an interview was conducted with the Director of Nursing (DON). When queried about what was put in place prior to the sexual abuse by R805 toward R804 on [DATE], the DON reported R805 was moved upstairs from the first floor due to wandering but was not sure about other interventions that were put in place. At that time, the lack of care planned interventions for wandering, despite being assessed as at risk, and having documented incidents of being in other resident's beds in the past, was discussed with the DON. At that time, any evidence of interventions put into place prior to [DATE] was requested. No additional information was provided prior to the end of the survey. On [DATE] at 2:22 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. The Administrator reported she was unaware R805 had previously documented incidents of wandering into other residents' rooms and going into their beds and confirmed there should have been interventions in place. The Administrator reported the facility verified the incident of sexual abuse did occur based on the observations made by staff. A review of a facility policy titled, Abuse and Neglect, updated [DATE], revealed, in part, the following, .Instances of abuse of all residents, irrespective of any mental of physical condition, cause physical harm, pain or mental anguish .It includes .sexual abuse .Sexual is defined as non-consensual sexual contact of any type with a resident .Sexual abuse include, but is not limited to unwanted intimate touching of any kind especially of breasts or perineal area .This would include, but is not limited to, nudity, fondling .Prevention .This includes an analysis of .The assessment, care planning, and monitoring of residents .who have behaviors such as entering other residents' rooms .

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): 3044078 and 3044417. Based on observation, interview, and record review, the facility failed to implement effective interventions for dementia related behaviors in a timely manner for one (R805) of one resident reviewed for dementia care, resulting in continued wandering behaviors and the resident climbing into bed with another resident, exposing his genitals, and touching the other resident's breast. Findings include:On [DATE] at approximately 8:30 AM, R805 was observed lying in bed with the privacy curtain pulled. R805 said hello in Spanish. Certified Nursing Assistant (CNA) 'E' was observed at R805's bedside. On [DATE] at 11:20 AM, R805 was observed lying in bed with the privacy curtain pulled. CNA 'E' was observed at R805's bedside. At that time, an interview was attempted with R805. R805 acknowledged he was able to understand English but did not speak it well. R805 answered yes and no to questions but was not able to give more detailed answers. On [DATE] at 11:25 AM, an interview was conducted with CNA 'E'. CNA 'E was asked why she was in R805's room with him. CNA 'E' reported she was assigned to be his 1:1 sitter. When asked why R805 required 1:1 supervision, CNA 'E' said she did not know. CNA 'E' said she thought it was because he wandered into other resident's rooms but was not positive. A review of R805's clinical record revealed R805 was admitted into the facility on [DATE] with diagnoses that included: Parkinson's Disease and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed no assessment of R805's cognitive status. The MDS noted R805 did not have any behaviors including wandering and required partial/moderate assistance with transfers and walking. A review of R805's Wandering Risk Scale assessments revealed on [DATE] and [DATE], R805 was assessed to be at risk to wander. A review of a General Progress Note dated [DATE] at 8:30 AM, written by Licensed Practical Nurse (LPN) 'F', revealed, writer was at medication cart when nursing aid approached cart to report (R805) in another resident's bed upon writers' arrival in room writer witnessed (R805) in the resident's bed and under the covers together writer called out for another nurse assistance previous shift (LPN 'G') approached room both nurses pulled the covers back writer seen (R805) undressed from waist down other resident was still in gown with top half down and breast exposed brief was still on person. (R805) was runed to his left up close on resident genitals exposed resident was laying straight back resident's face had beefy red discolor on their right side and face was turned to their left while body remained straight .(R805) stated he didn't know what happen, and he doesn't remember when writer asked translator to ask resident why he took his brief off resident stated it was dirty. Resident then said he had a headache rested his head back down and didn't answer any more questions .Further review of R805's clinical record revealed the following which indicated he had a history of wandering into other resident's rooms and going into their beds:A General Progress Note dated [DATE] noted, Res (resident) urinated in his how and garbage can on 2 different times today. also observed this morning sitting at the bed of another res. Res was assisted back to his own bed.A Mood/Behavior progress note dated [DATE] noted, Resident observed lying in another resident's bed wearing wet pants. Writer attempted to redirect resident to his own room for incontinence care with CNA assistance. Resident became agitated upon redirection and began yelling in Spanish. Resident then stood up from chair and continued yelling .It was documented in a General Progress Note on [DATE] that R805 was moved to a new room on the second floor from the first floor. There was no documentation as to why the room change was made. A review of the facility's investigation into the incident documented in the [DATE] progress note revealed, .Review of admission records and collateral information received from the resident's prior care setting identified a history of wandering and searching behaviors related to his deceased spouse .A review of R805's care plans revealed there was no care plan to address R805's known wandering risk, as documented in the progress notes and assessments, until after he was found in bed with another resident on (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]. On [DATE] at 12:01 PM, an interview was conducted with CNA 'C' who was the CNA who found R805 in another resident's bed on [DATE]. CNA 'C' reported when she opened the door to the other resident's room, R805 was lying in bed with the other resident and they were both underneath the blanket. CNA 'C' further said R805's brief was down and his genitals were out and the other resident's breast was showing. When queried about any previously known behaviors that R805 had, CNA 'C' said she was not aware of any behaviors. On [DATE] at 11:07 AM, an interview was conducted with LPN 'F', the nurse assigned to R805 on [DATE]. LPN 'F' explained that R805 was found in another resident's bed with his genitals exposed and the other resident's breast was exposed. LPN 'F' said she was unaware of any wandering or sexual behaviors exhibited by R805 in the past but reported she heard from a nurse that R805 was flirtatious and heard from a CNA that R805 wandered into other resident's rooms before. On [DATE] at 1:48 PM, an interview was conducted with the Director of Nursing (DON). When queried about what interventions were put into place when R805 was assessed to be at risk for wandering, the DON reported R805 was placed on the second floor. The DON reported typically the Interdisciplinary Team (IDT) would try to figure out what was triggering the resident's wandering behaviors so that interventions could be put into the care plan and implemented. The DON reported she was aware R805 had wandered into other residents' rooms and got into bed with them in the past, but that it was not sexual, but did not offer a response as to why there were no interventions put into place until after the incident on [DATE]. When queried about the facility's protocol to monitor behaviors for residents with dementia, the DON reported there was a physician's order to monitor the specific behavior every shift, and it would be signed off on the Medication/Treatment Administration Record and also could be documented by the CNAs. The behaviors were reviewed by the IDT to determine if any additional interventions were needed. At that time, a review of R805's Physician's Orders (active and discontinued) revealed no orders for behavior monitoring until [DATE]. Further review of R805's clinical record revealed no documentation that provided evidence of the IDT monitoring R805's pattern of wandering to determine the triggers or patterns. The DON was given the opportunity to provide any additional information regarding interventions that were in place and/or behavior monitoring for R805 prior to [DATE]. No additional information was provided prior to the end of the survey. On [DATE] at 2:55 PM, an interview was conducted with the Director of Social Services (DSS). When queried about how residents with dementia who wander were monitored for their behaviors, the DSS said she did wellness checks and activities staff did 1:1 activities to keep occupied. The DSS reported she referred residents with behaviors to the contracted behavioral health agency. When queried about who determined what specific interventions were appropriate, the DSS said the IDT determined the interventions, and they were added to the care plan. In addition, weekly behavior management meetings were held for residents on psychotropic medications or those with behaviors and/or dementia. When queried about whether R805 was reviewed in behavior meetings prior to the [DATE] sexual incident, the DSS said she was on leave when he was admitted and was not sure what was done before she returned. Since she returned, she started wellness checks. A review of a facility policy titled, Behavioral Management, dated [DATE], revealed, .The interdisciplinary care team identified underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to changes in the resident's behavior .Identified behaviors will be documented and tracked in the medical record .Behaviors and interventions will be addressed in the care plan .