STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235050	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to Intake: 2575125 Based on interview and record review, the facility failed to implement the abuse policy for reporting and response to allegations of abuse in 1 of 3 residents (Resident #102) reviewed for abuse, resulting in the potential for further allegations of abuse to be unreported. Findings include:Resident #101Review of an admission Record revealed Resident #101 was a male, with pertinent diagnoses which included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; mild cognitive impairment of uncertain or unknown etiology; and cognitive communication deficit. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Resident #102Review of an admission Record revealed Resident #102 was a male, with pertinent diagnoses which included: legal blindness, as defined in USA; essential (primary) hypertension (high blood pressure). Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 5/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #102 was moderately cognitively impaired.Review of Resident #102's Progress Note dated 7/28/25 at 3:41 PM and authored by Nursing Home Administrator (NHA) A revealed, Note Text: Regarding a possible altercation between this resident and another resident (referring to Resident #101) over the weekend. This resident said that another resident (referring to Resident #101) was saying some things that this resident found annoying and that was frustrating. This resident said he put his hands up to shoo the other resident away. This resident said no hotting (sic), slapping, or contact of any kind happened. Abuse could not be substantiated.Review of Resident #102's Case Management Progress Note dated 7/29/25 at 9:00 AM and authored by Case Manager (CM) F revealed, Note Text: Went down to check on (Resident #102) after the events of the weekend. I asked him about what happened and he stated that (Resident #101) came to his table in the dining room and started talking to him about the (group name omitted) and racial accusations. He stated that he was upset bythe (sic) conversation and wanted (Resident #101) to stop talking and swearing. When (Resident #101) wouldn't stop he hit (Resident #101) in the stomach because he felt frustrated.I asked him if he actually hit him, actually made contact with him and he said yes, in the stomach.Review of Resident #102's Social Services Progress Note dated 7/29/25 at 1:49 PM and authored by Manager of Case Management (MCM) G revealed, Note Text: Psychosocial visit after weekend events. Met with (Resident #102) to f/u (follow up) regarding peer-to-peer interactions. Reports he was frustrated with what peer (referring to Resident #101) was saying including racial and rude comments. (Resident #102) states he was trying to get him away and hit him. This writer asked if made physical contact, (Resident #102) confirmed he did.In an interview on 8/4/25 at 3:15, NHA A reported he initially had not been made aware of the interaction between Resident #101 and Resident #102 because it had occurred on a Sunday and he had not been made aware of it until the following Monday. NHA A reported when they were made aware of the interaction, Director of Nursing B had interviewed Resident #102 and he had said that he didn't slap Resident #101 but he was using his hands to shoo him away. NHA A reported the nurse (LPN N) who had responded was unaware that it needed to be reported immediately because she had not seen it happen. NHA A reported the interaction had not originally been reported to the State Agency because when he was made aware of it on that Monday morning, Resident #102 had reported he had not slapped Resident #101 but had been using his arms to shoo Resident #101 away. NHA A reported he had been made aware that Resident #102 actually hit Resident #101 today and would submit the incident to the State Agency. In an interview on 8/5/25 at 8:36 AM, Licensed Practical Nurse (LPN) N reported she had responded to the altercation between Resident #101 and Resident #102. LPN N reported she had not actually witnessed the altercation herself because she was on the unit passing medications at the time but what was told to her was that Resident #101 was calling Resident #102 a racist and then Resident #102 slapped Resident #101. LPN N reported when she arrived, the residents were no longer in a confrontation, and she addressed them both and told them they both lived at the facility and had to be respectful of one another. LPN N reported she then addressed Resident #102 and told him under no circumstances was anybody to lay hands on somebody else. LPN N reported she then had to go back to passing her medications. LPN N reported she did not report the incident to anyone that Resident #102 had hit Resident #101. LPN N stated that was my error. LPN N reported she should have reported the incident to NHA A within 2 hours but she totally forgot about it.Review

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to Intake: 2575125 Based on interview and record review, the facility failed to provide adequate supervision to prevent a resident-to-resident altercation for 2 (Resident #101, Resident #102) of 3 residents reviewed for abuse, resulting in Resident #101 making racial accusations to Resident #102 and Resident #102 hitting Resident #101 in the stomach. Findings include:Resident #101 Review of an admission Record revealed Resident #101 was a male, with pertinent diagnoses which included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; mild cognitive impairment of uncertain or unknown etiology; and cognitive communication deficit. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired.Review of Resident #101's Care Plan in place on 7/27/25 (at the time of the altercation) revealed, I have a potential for mood/behavior problem r/t (related to) ETOH (alcohol) abuse.I may yell out at staff or peers. last revised 1/23/25 with care planned interventions which included Remove resident from areas with other residents, as needed, when he is exhibiting inappropriate behaviors Date Initiated: 10/31/23. Resident #102 Review of an admission Record revealed Resident #102 was a male, with pertinent diagnoses which included: legal blindness, as defined in USA; essential (primary) hypertension (high blood pressure). Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 5/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #102 was moderately cognitively impaired. In an interview on 8/4/25 at 2:28 PM, Resident #102 reported he had an incident with another resident (Resident #101) about a week ago. Resident #102 reported Resident #101 had come up to him making racial accusations. Resident #102 reported he tried to tell Resident #101 to leave but he wouldn't. Resident #102 reported a friend at another table had kept telling Resident #101 to shut up. Resident #102 reported he got tired of what Resident #101 was saying and hit him in the belly. Resident #102 reported he was angry because Resident #101 wouldn't leave his table. Resident #102 reported he wasn't doing anything except waiting for his food to come when Resident #101 started all that. Review of Resident #102's Case Management Progress Note dated 7/29/25 at 9:00 AM and authored by Case Manager (CM) F revealed, Note Text: Went down to check on (Resident #102) after the events of the weekend. I asked him about what happened and he stated that (Resident #101) came to his table in the dining room and started talking to him about the (group name omitted) and racial accusations. He stated that he was upset bythe (sic) conversation and wanted (Resident #101) to stop talking and swearing. When (Resident #101) wouldn't stop he hit (Resident #101) in the stomach because he felt frustrated.I asked him if he actually hit him, actually made contact with him and he said yes, in the stomach. Review of Resident #102's Social Services Progress Note dated 7/29/25 at 1:49 PM and authored by Manager of Case Management (MCM) G revealed, Note Text: Psychosocial visit after weekend events. Met with (Resident #102) to f/u (follow up) regarding peer-to-peer interactions. Reports he was frustrated with what peer (referring to Resident #101) was saying including racial and rude comments. (Resident #102) states he was trying to get him away and hit him. This writer asked if made physical contact, (Resident #102) confirmed he did. In an interview on 8/5/25 at 8:36 AM, Licensed Practical Nurse (LPN) N reported she had not witnessed the altercation between Resident #101 and Resident #102 but responded to it. LPN N reported she had been on the unit passing medications at the time when somebody reported there had been an altercation between Resident #101 and Resident #102. LPN N reported it was a super busy day. In an interview on 8/5/25 at 8:48 AM, Dietary Aide (DA) E reported he had been preparing drinks for the lunch meal when he heard Resident #102 yell to Resident #101 that is racist. DA E reported at that point he went into the kitchen and told Sous Chef (SC) L what was happening. DA E reported he did not think there was any other staff in the dining room at the time. In an interview on 8/5/25 at 10:03 AM, SC L reported the serving staff (referring to DA E) had come to her during the middle of serving lunch and reported that Resident #101 and Resident #102 were arguing. SC L reported by the time she got to the dining room, the altercation had ended. In an interview on 8/5/25 at 11:00 AM, Unit Manager (UM) J reported on 7/27/25 when the altercation occurred between Resident #101 and Resident #102 during the lunch meal, Certified Nurse Aide (CNA) I and LPN M had been assigned to the dining room. UM J reported there was supposed to be 2 CNAs and 1 nurse in the dining room but there was only the 1 aide and the nurse that day because they had been down 1 aide and another aide had left at 11:00 AM. In an