| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235214 | A. Building<br>B. Wing | 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Harmony Village of Clawson | 535 N Main<br>Clawson, MI 48017 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s 2636124 and 2638469.Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for five residents (R's 302, 303, 304, 305 and 306) of six residents reviewed for abuse. Findings include:On 10/14/25 the medical record for R302 was reviewed and revealed the following: R302 was initially admitted to the facility on [DATE] and had diagnoses including Dementia, bipolar disorder and Schizophrenia. A review of R302's MDS (minimum data set) with an ARD (assessment reference date) of 10/2/25 revealed R302 needed supervision from facility staff with most of their activities of daily living.<br><br>A review of R302's careplan revealed the following: Focus-I have a history of demonstrating physical aggression towards others, staff and peers (Spitting, yelling, hitting). At times I pace and either swing my arms or make tight fist - both pose risk for injury. Date Initiated: 07/01/2025.<br><br>A review of R302's progress notes pertaining to resident-to-resident altercations revealed the following:<br><br>10/9/2025-Incident Note-Writer was at medication cart and resident approached me. He seemed upset and I gave him some med pass. He accepted it and walked away towards the receptionist. Other resident was sitting in his wheelchair and [R302] was approaching him yelling out. Receptionist went to get in between residents. Resident in wheelchair backed up and while backing up his wheelchair, he extended his left leg. [R302] then kicked the other resident in the left shin. Resident's were immediately separated and assessed. Resident was placed on increased monitoring, 1:1.<br><br>10/9/2025-Nursing: Incident Note-Report Type: Allegation of abuse-Description of what occurred: Resident kicked another resident in the left shin. Immediate intervention implemented: Resident placed on 1:1.<br><br>10/03/2025-Type: Practitioner Progress Notes-seen for eval as he was hit on head by another resident.<br><br>10/3/2025-Nursing Progress Note-Nurse was notified by CNA (Certified Nurse Assistant) that a female resident called her into her room and stated the following: Resident from room [R302's room number] [R302] entered the female's room, touched her breast, and then put his hand down her brief. At that time, she told him No and then he turned around and went back into his room. The female resident then notified the CNA about the incident. Nurse was notified. Assured residents were separated. Administrator and DON (Director of Nursing) notified. [R302] put on one-on-one observation immediately. Resident unable to give a statement regarding the situation due to his<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | medical dx (diagnosis). Police notified and investigated.Female resident stated that [R302] did not hurt her, she was just scared. Physician notified.<br><br>8/22/2025-Nursing: Incident Note-Report Type: Incident/Accident-Description of what occurred: Per receptionist she heard resident yell don't do that, stop. [R302] hit the other resident and I stepped in between them. [R302] turned around and walked away mumbling. Immediate intervention implemented: CNA stayed with resident, petition resident to ER (emergency room).<br><br>6/29/2025-Nursing: Incident Note-Report Type: Incident/Accident-Description of what occurred: Resident pacing in the hallways this morning and was reported by another resident that he had hit him. Immediate intervention implemented: Nurse stayed with resident Obtained vitals called doctor.<br><br>R302 and R306<br><br>A review of the facility reported incident (FRI) revealed the following documentation pertaining to R302 kicking R306 on 10/9/25:<br><br>Resident-to-Resident Altercation Investigation Report Date of Incident: October 9, 2025 Administrator: Resident #1: [R302] Resident #2: [R306] Type of Incident: Resident-to-Resident Physical Contact (Witnessed) Police Notification: [Police report number] Occurrence: On October 9, 2025, resident [R302] made physical contact with resident [R306]. Staff immediately intervened and separated the residents. A skin and pain assessment was completed on [R306], revealing a small bruise on his shin with pain rated 2/10. [R302] was placed on one-on-one supervision for the remainder of the day. The physician and legal guardian were notified. Immediate Actions Taken: Residents immediately separated following the incident. Skin and pain assessments completed on [R306]. Physician and legal guardian notified. One-on-one supervision initiated for [R302] for the remainder of the day. Three-day wellness checks completed on both residents.Interviews / Witness Statements: Witness (Nursing Staff): The nurse reported that [R306] had just finished receiving his medication and was walking down the hall when [R302] approached and began fussing. [R306] extended his leg defensively but did not make contact. [R302] then kicked [R306], striking him on the shin. Staff immediately intervened and separated the residents. Resident Statement [R306]: [R306] confirmed that [R302] kicked him on the leg. He rated his pain 2/10. Conclusion: After reviewing all interviews, documentation, and assessments, the facility determined that this incident meets the criteria for substantiated abuse. [R302] willful act of kicking another resident resulted in physical injury (bruise) and pain, as verified by staff witnesses and assessment. While [R302]'s cognitive impairment limits his understanding, the act itself was willful (not accidental) and resulted in harm, therefore substantiating the finding of resident-to-resident physical abuse. The facility's Abuse, Neglect, and Exploitation Policy was reviewed and followed. All required notifications, interventions, and follow-up actions were completed.<br><br>A Pain assessment dated [DATE] for R306 revealed the following: .G. Pain Management. 1a. Describe treatment, any side effects and effectiveness: Received scheduled pain medications and ice to area.<br><br>A progress note dated 10/9/25 for R306 revealed the following: Report Type: Allegation of abuse: Description of what occurred: Resident was kicked in the left shin by another resident. Immediate intervention implemented: Residents were separated and first aid administered to this re3sident <sic>.<br><br>R302 and R304<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the FRI pertaining to an allegation that R302 pushed R304 on 8/22/25 revealed the following:<br><br>Incident Summary: On Friday, August 22, 2025, at approximately 12:45pm the receptionist [receptionist F] reported to the administrator that resident [R302] pushed resident [R304] in the hallway. [receptionist F] immediately intervened, separating the two residents. Upon investigation it was determined that resident [R304] was ambulating in his wheelchair down the hallway as resident [R302] was approaching from the opposite direction. [R304] extended his foot outward, which [R302] perceived as an attempt to kick him. In response [R302] became upset and pushed him. Receptionist [receptionist F] promptly intervened to de-escalate the situation and ensured both residents were separated.<br><br>A witness statement from Receptionist F dated 8/22/25 revealed the following: I was at the front desk and saw [R302] walking down the hallway. [R304] was in his wheelchair rolling down the hall. [R302] walked up on him and pushed him. I jumped up and ran to them and separated them. I told [R302] that he can't put his hands on another resident and he pointed to [R304] and [R302] was kicking his foot saying [R304] was trying to kick him.<br><br>A progress note for R304 dated 8/22/25 revealed the following: Report Type: Allegation of abuse. Description of what occurred: Per receptionist, I heard yelling and went toward the yelling and as I arrived toward <sic> yelling near [room] 120 saw [R302] kick [R304] in the left hand. I immediately separated them. Immediate intervention implemented: pain assessment.<br><br>On 10/14/25 at approximately 1:22 p.m., Receptionist F was queried regarding the altercations between R302 and R304 and R306. Receptionist F Sated that they were at the front desk and saw R304 come down the hall in their wheelchair. R302 walked up to R304 and pushed him with both of his hands. A 1:1 supervision was started with R302. Both residents were using profanity, and they informed the Nurse. Receptionist F was queried regarding R302 kicking R306 in the shin and they reported they witnessed that happen as well, and it was in the same hallway where the front desk was located and that R306 was walking down the hallway and R302 saw them and got mad and then kicked R306 in the leg.<br><br>On 10/14/25 at approximately 2:46 p.m., the facility Administrator (abuse coordinator) was queried regarding the multiple physical abuse incidents involving R302. The Administrator reported that the incident on 8/22/25 involving R304 had been substantiated because it was witnessed by the Receptionist F. Stated R302 was separated from R304 immediately after the altercation and was provided a staff member for 1:1 supervision until they were transferred to the hospital. The Administrator was queried regarding the altercation between R302 and R304 and they indicated that they were still working on that investigation as it had occurred on 10/9 but that it was substantiated. The Administrator was queried about how they are trying to protect other residents from R302 and they indicated that they try to provide a 1:1 staff member for him when they notice him getting agitated and try to keep other residents away but that it is difficult because he is frequently impulsive.<br><br>R302 and R303<br><br>Review of a facility provided investigation revealed, .On October 3, 2025, at approximately 3:00 PM, (R303) was observed striking (R302) during an altercation. Based on staff witness accounts, resident interviews, and assessment findings, the investigation confirmed that [R303] struck [R302].<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the clinical record revealed R303 was admitted into the facility on 3/10/25 with diagnoses that included: stroke with paralysis affecting right side, dementia and major depressive disorder. According to the MDS assessment dated [DATE], R303 had moderately impaired cognition.<br><br>Review of R303's comprehensive care plan revealed a Focus created 10/8/25 that read, I have potential to demonstrate physical behaviors (hitting, slapping) r/t [related to] Dementia, Mental Illness.<br><br>On 10/14/25 at 1:47 PM, Staff D, who served as the Health Information Coordinator, was interviewed and asked if she witnessed R303 strike R302. Staff D explained she had just walked out of an office when she saw R303 stand up and smack R302 on the back of the head. Staff D was asked if she had ever seen R303 hit anyone before. Staff D explained she had not, R303 will cuss out other people, but had never seen him hit anyone before and had also not known R303 could stand, she had always seen him in a wheelchair.<br><br>On 10/14/25 at 1:52 PM, Unit Manager (UM) C was interviewed and asked about R303 hitting R302. UM C explained R302 was in her office to get a pop and he wanted some popcorn, so she was bending down to get the popcorn when she saw R303 stand up and hit R302 on the back of the head. was surprised, she did not know R303 could stand. R303 was not normally like that.<br><br>On 10/14/25 at 2:03 PM, R303 was observed sitting in a wheelchair in his room. R303 was asked why he had hit R302. R303 explained the night before (10/2/25) R302 was all up on LPN (Licensed Practical Nurse) A like he wanted to hurt her. so he planned an assault, in the morning he put on his brace so he could stand up and waited until he had an opportunity and assaulted him.<br><br>On 10/14/25 at approximately 3:05 PM, the Administrator was interviewed and asked about R303 hitting R302. The Administrator explained R303 was upset because he thought R302 was being mean to LPN A the night before and took it upon himself to correct R302. she had talked to him, and the police had talked to him and told him he could not take correction upon himself, he had to talk to the staff.<br><br>R302 and R305<br><br>Review of a facility provided investigation revealed on 6/29/25 R305 was sitting in the hall in his wheelchair when R302 hit R305 in the stomach and on the knee.<br><br>On 10/14/25 at 1:12 PM, R305 was observed sitting in a wheelchair in their room. R305 was asked about R302 hitting him on 6/29/25. R305 explained he was sitting in his wheelchair in the hall outside of his room, minding his own business, when R302 came and stood in front on him and got in his face. he tried to go around him, but he slapped his stomach and hit his right knee. he yelled and staff came then R302 walked away. R305 was asked if he had any interactions with R302 before this incident. R305 explained he had not. R305 was asked if he had any interactions with R302 since the incident on 6/29/25. R305 explained R302 wandered at night and would usually come into his room around 1:00 AM and just stand in his room.<br><br>Review of the clinical record revealed R305 was admitted into the facility on 6/11/25 and readmitted [DATE] with diagnoses that included: acute and chronic respiratory failure, heart failure and paraplegia. According to the MDS assessment dated [DATE], R305 had intact cognition.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/14/25 at 1:41 PM, CNA E was interviewed by phone and asked about R302 hitting R305. CNA E explained it was early in the morning, R305 had just gotten up and was sitting in the hallway, she was coming out of the soiled linen room when R305 yelled that R302 had hit him. CNA E was asked if R302 wandered during the night. CNA E explained R302 did wander frequently at night.<br><br>On 10/14/25 at approximately 3:05 PM, the Administrator was interviewed and asked about R302 hitting R305 on 6/29/25. The Administrator explained she was not the Administrator at that time, but the facility had petitioned R302 out to the hospital, but the hospital sent R302 right back to the facility.<br><br>Review of a facility policy titled, Abuse, Neglect and Exploitation revised 6/2023 read in part, .'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . 'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Prevention: . D. The facility will identify by ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict . |