STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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 - Minimal harm or potential for 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 3031211. Based on interview and record review, the facility failed to protect the resident's right to be free from staff to resident physical mistreatment for 1 (Resident #100) of 3 residents, resulting in Resident #100 experiencing physical injury, emotional distress, and fear. Findings include:Resident #100:Review of an Face Sheet revealed Resident #100 was a male with pertinent diagnoses which included paralysis on his right side due to a stroke, contracture (permanent tightening and shortening of muscles, tendons, ligaments, or skin) of right hand and right wrist, contracture of right and left knees, Alzheimer's disease (progressive disease which destroys memory, thinking skills, and the ability to carry out simple tasks caused by an abnormal buildup of toxic proteins in the brain), blindness one eye and low vision of other eye, weakness, and need for assistance with personal care.Review of Resident Profile for Resident #100 dated 07/07/2023 revealed bed mobility one person assist. One person assist was a single caregiver helps a resident change position in bed, such as rolling over, sitting up, or scooting up/down in the bed. Review of Incident dated 5/16/26 revealed, .Incident Summary: Resident reported to daughter that CENA beat him up. Nurse and daughter were able to narrow timeframe to when resident was speaking of. Identified CENA suspended immediately pending investigation. Resident reports that he feels safe in facility and nurse to perform skin and pain assessment. This investigation is on-going. Investigation Summary/Actions Taken: The resident alleged the incident had occurred around 4PM. The nurse (Licensed Practical Nurse (LPN) R) interviewed his CENA (Certified Nursing Assistant (CNA) F) who said she had cared for the resident during that time. CNA F was suspended pending investigation. Administrator reported allegation to the state of Michigan and the (Local) Police Department. The police officer who responded called the Administrator after interviewing the resident and his family. The police officer said the story that was given to him by the family and resident was all over the place and there were no injuries that were consistent with an assault. LPN R), LPN observed some small scratches and a small bruise on the bridge of the resident's nose. (LPN R) also performed a skin and pain assessment on resident with no other change from his baseline. The MD (Medical Director) was notified, and it was attempted to get urine so resident could be tested for UTI (urinary tract infection), but he refused.(CNA F), CENA states she arrived at 2PM for her shift. She changed (Resident #100) at 330PM, and he put his call light on again 4 PM and he said he needed to be changed. (CNA F) went in and explained that she had just changed him, and she was doing her rounds and that she would come back and change him. (CNA F) states that the resident became agitated and began cussing at her. (CNA F) states that she was not comfortable going back in the room by herself because he was calling her racial slurs and names.she went and got (CNA Q), CENA. They then went and changed the resident together and the resident did not voice any concerns to them at any point during his care.Investigation submitted on 5/26/26 at 5:44 PM. In an interview on 6/16/26 at 12:24 PM, LPN R reported she was down on the 100 hallway, when Registered Nurse (RN) CC came to her and informed her an incident happened with Resident #100. LPN R reported Resident #100 informed her he had wanted his brief changed and he felt the CNA didn't want to do it, and he told her fine, don't (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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 - Minimal harm or potential for actual harm Residents Affected - Few	do your job and the CNA had started to hit him, she had slapped him. LPN R reported when she assessed Resident #100 he had a bruise on his nose, abrasion on his forehead, and scratch under his eye. LPN R reported the bruise was a fresh bruise as well as the abrasion and the scratches. LPN R reported she had been assigned to Resident #100 the evening shift prior (5/15/26) and there was no skin impairment. When queried if Resident #100 was combative with cares, LPN R reported he was not, she never had a problem when she cared for him and would announce herself when she came in the room, he would greet her warmly. LPN R reported Resident #100 liked to have his eye drops first, asked to have his hand and legs adjusted because of his contractures. LPN R reported Resident #100 liked to have his care done how he liked to have things done. LPN R reported Resident #100 can shift himself in bed but not really well, he used the side rails and assist bars to help shift his body. LPN R reported Resident #100 had contractures to his legs, his right hand, and was impaired on his right side due to a stroke. LPN R reported she took care of Resident #100 frequently and he was able to recognize her by her voice. LPN R reported she had contacted the Nursing Home Administrator (NHA) and informed her of what had happened, the police came to speak to the resident and his family were present, and he asked for CNA F's phone number to contact her as she had been suspended pending investigation.In an interview on 6/17/26 at 11:06 AM, RN CC reported she was walking past Resident #100's room and was stopped by his wife and daughter and asked to come in Resident #100's room and his wife proceeded to tell me she was very upset. RN CC reported it was reported one of the CNAs was in his room earlier, and Resident #100 was claiming the CNA had slapped and scratched him in his face. RN CC reported she did observe Resident #100's face and he did have marks on his face, scratch under his eye, redness on his forehead, as well as there was redness on his face. RN CC reported the injuries appeared to be recent as there was no closing of the scratches, not scabbed over, appeared to have red fluid the length of the scratches. RN CC informed the family she would go and get his nurse, LPN R to come and speak to them. RN CC reported she entered Resident #100's room with LPN R and she had started speaking with Resident #100 and he had reported he didn't recognize the voice, so he did not know who did it, but they had scratched him on his face and slapped him. RN CC reported Family Member (FM) Y reported Resident #100 had an [NAME] (smart speaker, artificial intelligence powered with a screen to make video calls and watch streaming services) in his room and he had used it to call them, she and FM M came to the facility. RN CC reported she was assisting with interpreting as family members were speaking to her in Spanish. RN CC reported Resident #100 was able to speak and understand English and he reported he had pressed the call button to get assistance as he needed to be changed, reported the CNA had an attitude when she came in, Resident #100 told her if she was going to have an attitude to leave the room, he didn't want to deal and it escalated pretty quickly, she was upset, they argued, and Resident #100 had snapped back at her telling to do it or just leave. Resident #100 reported the CNA proceeded to slap him and scratch him while she provided the care to him. Review of Skin Assessment dated 5/15/26 at 7:13 PM, revealed it was a weekly skin assessment and Resident #100 had no areas of skin impairment. Review of Skin Assessment dated 5/16/26 at 7:04 PM, revealed .R (Right) eye abrasion, bruising on nose, forehead red slight abrasion.Review of Progress Notes dated 05/18/2026 at 04:27 AM, revealed, .Able to make wants/needs known refused to have UA (urinalysis) done states I am not confused I know what happened. Review of Progress Notes dated 05/17/2026 at 12:37 AM, .A&O (alert & oriented), able to make want/needs known, medicated for c/o (complaint of) pain/discomfort w/ (with) effective results.During an observation on 6/16/26 at 2:40 PM, Resident #100 was observed lying in his bed, supine, upper body leaning slightly to the right side, covered in a blanket, lights dimmed. Had his rolling bedside table on the left side of the bed. Resident #100 appeared frail in appearance. His bed was noted at a slight angle and not against a wall. During an observation and interview on 6/16/26 at 3:10 PM , Resident #100 was awake in bed. Pleasant in conversation. Stated female staff came in to provide cares and told him to grab the rail to roll himself over. He said it was hard for him to roll over, and he reported he was hit by a female staff. I am blind and can only use my (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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 - Minimal harm or potential for actual harm Residents Affected - Few	left arm. Staff are to help me. If they cannot do their job then they do not need to be here. I do not know who the aide was. They were female that is all I know. I told (LPN R) the nurse and called my wife right away. My wife took pictures of my face. How do I protect myself? I am blind and have the use of one arm.Review of Social Services Note dated 05/18/2026 at 03:51 PM, revealed, .Resident is alert and able to make his needs known.Writer spoke with resident regarding allegation.Resident stated he is uncomfortable at times when using his call light because he does not want to upset staff. Writer allowed resident to express his feeling then offered emotional support. Resident was encouraged to continue using call light for needs and he was informed that all concerns will be taken seriously. Nursing and Administrator were notified of resident's statement. Family was present during visit. Staff will continue to observe and report any changes in mood and/or behaviors. In an interview on 6/17/26 at 11:29 AM, Social Worker (SW) Z reported when she went in to speak with Resident #100 on 5/18/26 in regard to the incident that happened over the weekend on 5/16/26. SW Z reported Resident #100 was very clearly upset when she spoke to him and he reported the female staff member came in his room and hit him, SW Z reported she was informed he had been punched in the face so she expected to see larger bruising but he did have marks on his face, something by his eye and bruising on his nose, and then the female staff member returned with a second person to provide care for him. When queried about his concern with using the call light, SW Z reassured him the staff member would not be providing care to him anymore and he should continue to use his call light for his needs. SW Z reported she was unsure if he was comfortable staying at the facility, but the family preferred the location of the facility. In an interview on 6/17/26 at 12:57 PM, CNA F reported she worked on second shift on 5/16/26, reported at 2:00 PM. CNA F reported she had completed a brief change on Resident #100 and he had pressed his call light a little while later approximately 45 minutes to an hour later as she was completing her rounds for check and changes with other residents and he had indicated his brief needed to be changed. CNA F reported she had informed him she was completing check and changes with other residents who hadn't been changed yet and she needed to get to them first. CNA F reported this infuriated him and he began yelling and calling her names she did not want to repeat what he had said to her. CNA F reported she had told him Okay and she left in search of someone to come and assist her as she did not feel comfortable going in his room without another staff. CNA F reported she had found CNA Q to come and assist her provide care to Resident #100 and at that time he was pleasant there were no issues. CNA F reported approximately an hour later the nurse came up to her and was asking questions about Resident #100's face as he had scratches and had indicated she had slapped him. CNA F reported at that time she was send home due to being suspended. She reported she had left the building at approximately 7:00 PM. When queried on Resident #100's bed mobility, CNA F reported she had to help him roll over on to his side, she had to position him on and off the rail but once there he was able to hold the bar but not for an extended period of time as he had only the use of his left hand. CNA F reported when he lost his grip she would have to push him back over to where the bar was for him to hold on while she was trying to complete the brief change. CNA F reported Resident #100 cannot pull himself over, had little movement, and can only turn with assist. CNA F reported she had to assist Resident #100 as well because he was legally blind. CNA F reported she was unsure how he had received the marks and scratches to his face, and she did not notice them when she provided care to him both times that day. CNA F reported while she was providing care for him and while CNA Q was in the room with them, Resident #100 did not hit his face, she did not push him over hard enough to hit his face on the enabler bar, and he did not hit his head eitherIn an interview on 6/17/26 at 12:25 pm, Shower Aide AA reported she did observed marks on Resident #100's face when she provided him with a shower on 5/18/26. Resident #100 had scratches on his face and above his eyebrow, and a bruise on his nose. In an interview on 6/16/26 at 1:29 PM, CNA P reported Resident #100 was usually pretty quiet, didn't' ask for much and was able to make his needs known. CNA P reported the resident did have an Alexa device in his room to make phone calls. CNA P reported Resident #100 was able to help roll on his (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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 - Minimal harm or potential for actual harm Residents Affected - Few	side a little bit, but he had contractures due to a stroke. CNA P reported Resident #100 could be verbally aggressive, but he was not physically aggressive with staff.In an interview on 6/16/26 at 12:54 PM, CNA G reported 5/16/26 was a Saturday. CNA G reported she had no problems with Resident #100 as he let her change him, helped him with his meals but at times he does try to start an argument as he liked things done a particular way he liked them done, and if he feels like you're resistive to providing care to him he would say if you're tired get out of her, or if you don't feel like doing it (brief change) then don't, just leave. CNA G reported she would ignore his statements and provide his care; he didn't give her much trouble and let her provide his care. CNA G reported Resident #100 was a one person assist with bed mobility and cares, and he was a Hoyer transfer out of bed. CNA G reported Resident #100 did not like CNA P and he would tell her to get out of his room so they usually switched, and she would take care of Resident #100. CNA G reported he knew who CNA P was by the sound of her voice. In an interview on 6/16/26 at 1:05 PM, CNA Q reported she had worked 12 hours that day, and she had come in early at 10:00 AM. CNA Q reported when she and CNA F went into Resident #100's room to do a brief change, he was very quiet, she reported she was not sure what happened if he was mad, maybe. CNA Q reported she did not pay attention to his face, she went in and assisted with care and left. CNA Q reported Resident #100 was able to assist with bed mobility by grabbing the enabler bar to hold himself on his side. CNA Q reported she doesn't have any problems with Resident #100 and he usually talked to her. During an observation and interview on 6/17/26 at 3:07 PM, FM M and FM Y reported Resident #100 had called FM Y via the Alexa device. This writer observed an Amazon Echo (smart device with a visual display, has [NAME] services, can be used to make video calls, watch streaming services, and browsing) on Resident #100's table facing towards his bed. FM M reported Resident #100 had called he reported to them a female staff member had come into his room and had hit him, asked them to call the NHA to inform her of what had happened. FM M reported she had attempted to call the facility and no one had answered the phone. FM Y had contacted the son to come and get them to take them to the facility. FM M reported FM Y had indicated Resident #100 sounded scared and confused as to why someone would do that to him. During an observation, Resident #100 was lying supine with both of his legs leaning to the left side, both were bent at the knee and FM M reported this was the most comfortable position for Resident #100 due to his contractures to his legs, he had a right hip replacement and it was painful, and he had paralysis to his right side due to a stroke. Resident #100 had his right hand/wrist in a splint. Resident #100's bed had rectangular enabler bars on both sides, open in the center, on the right side he had a plastic basket attached to the bars by zip ties to the outside of the enabler bar, he had a night stand on the left side of his bed, and he had a rolling bedside table next to the left side of the bed. Resident #100's nose did not have a dark spot on it which could be misconstrued as something else other than a bruise on 5/16/26. Resident #100 reported if the staff don't want to take care of him, then don't, but don't be mean and hit him. Resident #100 reported he just wanted to be safe at the facility. Review of photos of Resident #100's injuries revealed he had a red/pink scratch underneath his right eye running horizontally with his lower eye lid, he had a scratch on his forehead running up and down above his inner right eyebrow which appeared to be open as there was blood present, he had scattered areas of purpura (red/purple spots when small blood vessels leak blood underneath the surface) across the top of his forehead from the right side to the middle with some swelling of the area, and what appeared to be a bruise which was deep red and purple in color midway down on the right side of his nose running across the top of his nose partially which measured approximately an inch long. Review of Police Report from (Local) Police Department received on 6/17/26, revealed, .I made contact with (Resident #100) at the (Facility). (Family Member Y) and (Family Member M), were also present on scene. (Family Member M) advised that (Resident #100) primarily speaks Spanish and has limited English proficiency, and that she could assist with translation if needed. (Resident #100) is also blind.(Resident #100) stated that on today's date he activated the indicator light in his room requesting nursing assistance to help change his clothes and diaper. (Resident #100) stated that, for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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 - Minimal harm or potential for actual harm Residents Affected - Few	no apparent reason, the nurse began striking him in the face. (Resident #100) stated he was struck numerous times but was unable to provide an exact number or state whether the strikes were closed-fist punches or open-handed slaps. (Resident #100) stated that after a brief period, the nurse stopped striking him, left the room, and later returned with a second nurse. (Resident #100) stated the two nurses then assisted him in changing his clothes and diaper. (Family Member M) stated that she and (Family Member Y), were the first individuals (Resident #100) told about the incident and that they reported the allegation to nursing home staff. (Family Member M) stated that she and (Family Member Y) visit (Resident #100) frequently and had visited him the previous day. (Family Member M) stated that on the previous day (Resident #100) did not have the cut underneath his right eye, the red marks on his forehead, or the bruise/scrape on his nose. (Family Member M) stated those injuries were new as of today's date. INJURIES: (Resident #100) sustained a laceration below his right eye, a scrape on his nose, a scrape above his right eyebrow, and redness/irritated skin on his forehead. I photographed the injuries and uploaded the photographs. CONTACT WITH (CNA F) (SUSPECT): I made contact with (CNA F) via phone call. (CNA F) stated that (Resident #100) activated his indicator light requesting nursing assistance. (CNA F) stated she responded to (Resident #100)'s room and observed him to be irate, which she stated is normal behavior for him. (CNA F) stated that rather than attempting to assist (Resident #100) alone, she left the room to retrieve a second nurse before providing care. (CNA F) stated that while assisting (Resident #100) in changing his clothes and diaper, his face may have scraped against one of the bedside rails, which she believed could explain the scratches on his face. (CNA F) denied striking or otherwise harming (Resident #100).CONTACT WITH (CNA Q): On 21 May 2026, at approximately 1800 (6:00 PM) hours, I made contact with nurse (CNA Q), who assisted (CNA F) in helping (Resident #100) change his clothes. (CNA Q) stated that (CNA F) requested her assistance in changing (Resident #100). (CNA Q) said that when (CNA F) came to her for help, (CNA F) did not mention (Resident #100) acting out of the ordinary. (CNA Q) advised that (Resident #100) is often very rude and gives the nurses a difficult time while they assist him with changing and other tasks. (CNA Q) stated that she assisted (CNA F) in changing (Resident #100) without incident. (CNA Q) stated that (Resident #100) was quiet and compliant the entire time she and (CNA F) were assisting him. (CNA Q) stated that she did not recall (Resident #100)'s face hitting any of the bed rails. (CNA Q) also advised that there are no cameras inside the facility.Charges Requested: This report will be forwarded to the (County Name) Prosecutor's office for review of assault charges against (CNA F) . In an interview on 6/16/26 at 4:08 PM, NHA A reported she had contacted the local police and spoke to the officer who reported to the facility on 5/16/26, but she had lost the call as she had been out on her boat. She reported she did not have the officers name or the report number. NHA A reported she did not request a police report and after this writer requested it, submitted a request with the local police department for the report. In an interview on 6/17/26 at 2:09 PM, Director of Nursing (DON) B reported staff were instructed per policy to contact the abuse coordinator when an incident occurred. DON B reported for any clinical concerns, staff were to contact her or Unit Manager DD as they were to be available 24 hours and switched weekends for on call. When queried if the on call clinical administration should have responded to the incident, DON B reported the primary nurse was instructed to conduct a head-to-toe assessment, complete a skin assessment and a pain assessment. DON B no clinical administration reported to the facility. In an interview on 6/17/26 at 2:15 PM, Nursing Home Administrator (NHA) A reported SW Z' had reported to her the family was upset, she was able to provide reassurance to them, and SW Z had come and informed her of the details of the situation she had learned of the incident. NHA A reported the progress noted entered into the medical record was the statement from SW Z where she went to speak to Resident #100 in regard to the incident. There was no other statement from SW Z. When queried if SW Z had informed NHA A Resident #100 had reported one person came in and performed care and he was assaulted then and then the female person came back with another female person and did a brief change again on him, NHA A reported she was not aware of that. NHA A reported CNA (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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 - Minimal harm or potential for actual harm Residents Affected - Few	F went in approximately 3:30 PM and performed care on Resident #100 and went back in at approximately 4:00 PM she wouldn't be able to change him right then. NHA A reported she was not aware of the approximate time CNA F and CNA Q went in to Resident #100's room to perform care. When queried when LPN R was informed and went to assess Resident #100, NHA A reported she did not know that. When queried after review of the police report if NHA A would have changed her thoughts on the root cause of the events, she reported she felt no abuse occurred, there was no proof of abuse occurring, and the officer felt no abuse occurred. NHA A reported when an analysis was completed of the incident she came to the conclusion Resident #100 had received the injury from the enabler bar on his bed, and indicated the injuries were consistent with hitting his face on the enabler bar. NHA A reported she had worked in therapy prior to becoming an NHA and she reported she believed he was able to partially assist with bed mobility but was unsure. In an interview on 6/17/26 at 2:32 PM, DON B reported following review of Resident #100's medical record he was a one person assist with bed mobility. DON B reported the analysis was Resident #100 was able to reach over and grab the enabler bar without assistance and he had bumped his nose on the enabler bar. DON B reported the mark on Resident #100's nose was not a bruise but a discoloration when she and the provider assessed him on 6/20/26. DON B reported the other nurses who took care of Resident #100 following the incident reported it wasn't bruising but purpura. Note: review of the medical record revealed no documentation for the nurse who assessed him or other nurses who provided care to him following the event supported the injury was purpura and not a bruise. In an interview on 6/17/26 at 4:01 PM, NHA A and DON B reported when queried why Resident #100's statement was not included in the investigation, it was reported Resident #100 was insistent with his recollection of events, which he stated he had been hit by someone who entered his room and performed care on him and they believed the root cause was Resident #100 had hit his face on the enabler bar on his bed. Review of Resident #100's care plan did not indicate the resident made false allegations against staff prior to this incident. Review of the focus revealed last revised on 05/22/2026 at 01:10 PM. No new interventions were created for Resident #100's care plan. Review of policy, Abuse Prevention Program Policy & Procedure reviewed on 1/2026, revealed, .Each resident has the right to be free from abuse, neglect, and corporal punishment of any type by staff or anyone. The facility will provide a safe environment and protect residents from abuse.Staff to Resident Abuse: All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population.Staff will held accountable to their actions to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment. (Corporate) will not consider striking a combative resident an appropriate response in any situation. It is also not acceptable for any staff member to claim his/her action was reflexive or a knee-jerk reaction and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended, is unacceptable and must be cited.Possible Indicators of Physical Abuse: Bruises, including those found in unusual locations such as the head, neck, lateral locations on the arms, or posterior torso and trunk, or bruises in shapes (e.g., finger imprints); and Facial injuries, including but not limited to, broken or missing teeth, facial fractures, black (eye(s), bruising, bleeding or swelling of the mouth or cheeks.Mental abuse is the use of verbal or nonverbal actions, which cause or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.