STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 2704522. Based on observations, interviews, and record review, the facility failed to protect two residents' (R401 and R403) right to be free from physical abuse by a resident (R402) of 8 residents reviewed for abuse, resulting in potential for psycho-social decline, fear of recurrent assault, and fear of pain and discomfort from physical assault. Findings include: Incident #1: (Residents R402 and R403 altercation on 12/7/25): A review of the Facility Risk Management Report #1333, dated 12/7/25 at 14:45 (2:45 PM), revealed: Type of Incident: Resident-to-Resident Altercation. Incident Location: Dining Room. Nursing Description: Was informed resident was in the dining room on the first floor and was hit in the face 3 times by another resident. Resident Description: Resident was unable to give a description. Other info: Resident (R403) was in the dining room waiting for smoke break time. Writer (Nurse A) was informed that another resident (R402) hit him in the face. A review of the following statements pertaining to the resident-to-resident altercation on 12/7/25 revealed:Nurse A on 12/7/25 wrote: There was a page overhead for help in the downstairs Dining Room. The writer was informed that my resident (R403) was hit in the face three (3) times by another resident (R402). He was brought back to his room on the 3rd floor. DON was aware of the situation. The current Administrator #2 on 2/11/26 at 2:00 PM revealed that, after the 12/7/25 incident (R402 and R403 altercation) was reviewed, we deemed the incident should have been reported to the state. The timeliness for this particular investigation showed that the Verification of Investigation Summary was completed on 2/5/26, equivalent to 60 days to be exact, from the incident of Resident-to-Resident Altercation that occurred on 12/7/2025. The facility investigation concluded: In conclusion: The facility acknowledges that the allegation of a physical altercation between residents was identified and taken seriously. Prompt follow-up, interviews by the administration were conducted with all parties involved. Certified Nurse Aide (CNA B) statement on 12/7/25 revealed: Standing at the counter, just arrived, looked in the dining room, and Resident (R402) hit Resident (R403) in the face three (3) times I went to stop it, and he (R402) then hit me in the face. After we separated R402 and R403 he (R402) went after another resident, B.B. Then Nurse B.J. Had a hard time assisting the resident back to the unit for safety. CNA B during the interview by phone conducted on 2/11/26 at approximately 7:45 AM, indicated that she witnessed R402 attack R403 in the first-floor dining room. CNA B described that she was standing at the receptionist desk when she heard yelling, and saw R402 punch R403 on the face three (3) times. R402 was standing on top of R403, who was sitting in his chair. R403 was unable to fight back. CNA B quickly tried separating both and received a hard punch on her face from R402. CNA B described how strong and hard a punch was. After successfully separating residents, R402 started swinging at other residents and staff. CNA 'B observed R403's apparent bruising on the face. When asked how R402 is like, CNA B described R402 as easily getting agitated, swearing and yelling a lot, and repeating the same words loudly. Staff E on 12/7/2025, wrote, (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	R402 came out of the elevator towards the first floor dining room, cussing and yelling out the F word. CNA B told Staff E that R402 had the same behavior as yesterday. Staff E and CNA B noticed R402 was getting louder. Staff E said that CNA B walked towards the Dining Room, and CNA B yelled that R402 had hit another resident (R403). Staff E got up from the front desk office towards the Dining Room and saw R402 standing and swinging at CNA B while CNA B tried to keep R402 separated from R403. Staff E called other floor staff for help. Staff AP on 12/7/25 wrote, noted that she brought R402 back upstairs immediately, while the nurse (writer) told Staff AP that R402 was arguing with another resident, BB, and hit R403 in the face 3 times in the dining room.In the facility Risk Management Report, it was noted that the Director of Nursing (DON) was notified on 12/7/25 at 1624 (4:24 PM), approximately 2 hours after the incident occurred. According to the Director of Nursing (DON), during an interview conducted on 2//12/26 at 12:15 PM, she was aware of the resident-to-resident altercation incident that occurred on 12/7/25 between R402 and R403. The DON revealed that the abuse coordinator determined it was not reportable. Although it was witnessed by staff, R403 was unharmed and gave a thumbs-up when asked if he was okay. Abuse was not substantiated and was not reported to the state. Resident 403 (R403): R403 was [AGE] years old and was admitted to the facility on [DATE]. According to the Psychiatry follow-up dated 11/28/2025, his Brief Interview for Mental Status (BIMS) score is 0/15. A score of zero indicates severe cognitive impairment. It suggests the individual has significant difficulty with memory, orientation, and understanding. It is the lowest possible score, typically reflecting an inability to recall words or answer questions correctly. R403 was diagnosed with Hemiplegia and Hemiparesis affecting the Right dominant side after an intracranial bleed, Major Depression and Anxiety Disorder, in addition to other diagnoses. R403 was taking paroxetine HCL 10 mg 1X daily for mood, divalproex 250 mg delayed release 1 tablet daily (Mood stabilizer), and Seroquel 25 mg 1 tablet by mouth at bedtime. On 2/12/26 at 11:30 AM, a review of R402 and R403 clinical records was conducted. , there were no follow-up progress notes, post-assault assessments, entered in the Electronic Medical Record EMR pertaining to the resident-to-resident altercation. There was no follow-up assessment after 3 blows to R403's face were received. No notes, no description as to facial redness, bruising, or discoloration. No progress notes regarding R403's physical, social, or emotional status. There was no follow-up documentation for the signs and symptoms of pain. There was no record of a post incident assessment made by a Physician or Nurse Practitioner/physician assistant being in R403's records. There was no psych service referral, evaluation, or therapy referral performed for both residents, post incident. Resident #402 (R402): R402 was [AGE] years old admitted to the facility on [DATE]. According to the Social Service Director (SW I) dated 12/23/25, R402 had a BIMS score of 11/15. According to Cleveland Clinic (9/9/25), a BIMS score of 11 indicates the person has mild cognitive impairment (BIMS scores range from 8-12). According to his psychiatry follow-up dated 11//28/2025, R402 was on 3 medications: recommended by pharmacy for a Gradual Dose Reduction, namely, Seroquel 100 mg tablet for Dementia with associated psychotic and or agitated behaviors, and Depakote 500 mg tablet extended release 24 hours for Mood Stabilizer, and Sertraline 100 mg tablet for antidepressant. According to the Nurse practitioner, R402 is stable with no distress or worsening of behavior. After the incident on 12/7/25, R402 did not receive any psych or behavior referral until 1/13/26. During this follow-up psychology visit, the evaluation did not mention or refer to any incidents related to a resident-to-resident altercation that happened on 12/7/25 and 12/27/25. A Physician's Recommendation/Response for R402 post incident on 12/7/25 at 16:09 (4:09 PM), noted: Send to hospital for further evaluation and treatment as indicated related to behaviors. However, a Decline Order was noted on R402's Nurses Notes dated on 12/7/25 at 16:09. Noted text: Send patient out to hospital (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	for further evaluation and treatment related to behaviors. After a mental status change, the resident is not being sent out per management request; the resident is going to be one-on-one for behaviors. The DON on 2/12/25 at 12:10 PM explained that: It must have been the Abuse Coordinator's decision to not send him out instead to provide 1:1. On 2/12/26 at 12:15 PM, the surveyor requested documentation and behavior observations related to the one-on-one (1:1) details starting on 12/7/25; however, the corporate staff and DON were unable to locate any documents to support the one-on-one supervision. A midnight staff member was assigned for 1:1 on 12/7/25, but none was presented to the surveyor on the next day or any day thereafter. There was no documentation of the start and end dates for the one-on-one planned intervention. No documentation of outcomes was found to demonstrate the intervention's effectiveness. A review of R403 progress notes found no entries after 12/7/25 until 12/30/25. This was confirmed by the facility's corporate nurse, who was on-site on 2/12/26 at 1:39 PM. When the corporate staff was asked, she did not respond. Staff member E on 2/11/26 at (time) described the incident that occurred on 12/7/25. She was the receptionist that day and stayed behind the receptionist and did not see the hitting but heard all the yelling and called for other staff overhead after she heard CNA B screaming that R402 was hitting R403. CNA 'B' saw the hit and was trying to separate the 2 residents. Staff E called other staff by paging them overhead to come to the first-floor dining room, where the altercation occurred. After the review of records, the Director of Nursing and Corporate Nurse at the facility on 2/12/26 at 1:39 PM confirmed that no documentation was entered in R403's Progress notes post-incident regarding the resident-to-resident altercation on 12/7/2025. There was no record of follow-up assessments. No post incident assessment was done by the MD/NP, and no psych referral notes were found in R403's clinical record. On 2/11/26 at 3:30 PM, SW1 stated she did not see R402 and R403 post incident. Not seen by a psych, not received psych services.2/12/26 at 12:15 Maintenance stated no video was retrieved. There is a video, but only available for a week. He did not recall looking for a specific incident, a resident-to-resident case in the dining area for both residents in question. SW I admitted not seeing the R402 after the 12/27/25 incident with R401. His BIMS Score is 11, but we don't know what triggers him to get agitated. The surveyor asked whether he often exhibits impulsive behavior. SW I stated that it has been observed often as his baseline, and they do monitor him on the behavior log called Task Behaviors. We tried putting him on anger management, but he was not receptive to it. He is delusional without triggers and unpredictable. SW I continued and described R403 as a sweet person and would never initiate any violent or physical altercation. He has a BIMS of zero. R403 was not seen by behavior services after the December 7, 2025, incident. He was seen later on January 8, 2026 (1 month after the incident). When asked why it took a month for Psych Services to see him. SW I did not have an answer. SW I revealed that she did not have a progress note entry for R403 because I did not know or hear about it. But the DON wrote about a referral, but they did not inform her. SW I denied knowing about the referral she was supposed to schedule. She did not send any referrals to psych services for both R402 and R403.Psychiatry Follow-up services dated 1/8/2026 were noted that R403 was last seen on 11/28/25. There was no indication in the 4-page evaluation that the Nurse Practitioner was aware of the resident-to-resident physical altercation that occurred on 12/7/25. Incident #2: Resident-to-Resident Altercation on 12/27/25 (R401 & R402): On 2/10/26 at 4:00 PM, the document labeled DON Investigation dated 1/2/26 (no time) was reviewed. It wrote: Resident R401's (first and last name was written) was interviewed and reported that she was assaulted in the day room near the refrigerator when another resident entered the area. R401 reported that R402 (the resident's initials were written) became visibly agitated and struck her multiple times, knocking her glasses off. Staff immediately intervened upon observing the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	interaction and separated both residents. The DON was interviewed on 01/26/2026 at 3:30 PM and requested the facility's investigation of the R401 and R402 incident that occurred on 12/27/2025. The DON verified that she was notified by phone about the incident on 12/27/25. She explained that since it happened on the weekend, she was not present at the facility. Instead, she completed the Facility Risk Management documentation and the investigation upon her return on 1/2/2026 (7 days after the incident). The DON stated no abuse occurred, and the incident was deemed not reportable because they did not substantiate that abuse took place. On 1/26/25 at 4:00 PM, the facility administrator #1, who was also the abuse coordinator, was not able to provide a full investigation at the time of the request. The Administrator #1 explained that it was not substantiated and was not deemed reportable. The Abuse coordinator was asked how they analyzed and came up with the conclusion of not substantiating abuse. She stated that there was no witness that she was assaulted. The Abuse coordinator was then asked if an alleged assault was reportable according to your policy. The abuse coordinator did not respond. The timeliness for this particular investigation Incident #2 involving (R401 and R402) showed that the facility's Verification of Investigation Summary was completed on 1/27/26. It took the facility 31 days to be exact, to complete the investigation and determine if the abuse is substantiated or not after a witnessed Resident-to-Resident Altercation occurred. The facility investigation concluded: that Res. #2 (R402) reported making physical contact with Res #! (R401) .In conclusion: The facility has determined that the allegation of abuse is unsubstantiated . A review of the police report dated 12/27/25 at approximately 6:29 PM revealed that officer F responded to the 911 call and, upon arrival, interviewed the complainant (referred to as R401), who stated that R402 (referred to as the assailant) punched her on the face. Officer F noted in his report that he observed a slight redness on the right side of R401's face. R401 was asked by the officer if she knew why R402 punched her. R401 replied that she was not sure why R402 punched her on the face. During the interview with R402, Officer F written report revealing that R402 was described as having difficulty communicating. When Officer F asked R402 if he punched R401 on the face? R402 told the officer Yes, and then he made a motion like he balled his fist up and swung a punch. Although the police officer's report redacted some words, the officer clearly wrote that Due to the male's (redacted words) was unable to be placed in handcuffs or lodged at jail (name of county mentioned). Reviewed Police report Case No. 2539906252 on 2/10/26 at 4:00 PM. Resident 401 (R401): R401 was [AGE] years old and admitted on [DATE] with the diagnosis of Bilateral Osteoarthritis of the knee, Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Schizophrenia, and anxiety disorder in addition to other diagnoses. According to the assessment dated [DATE], R401's BIMS score was 13/15. A score of 13-15 indicates that a person is cognitively intact. It signifies normal memory and thinking skills with little to no cognitive impairment. R401 takes Depakote 250 mg delayed-release (2 tablets at bedtime), Paxil 20 mg (1 tablet daily), Fluphenazine decanoate 25 mg/ml injection every 2 weeks, and trazodone 100 mg tablet daily. Nurse's notes dated 12/27/25 at 1815 (6:15 PM) were reviewed. Nurse wrote: Resident was attacked in the day room by R402 (writer used the resident's room number as identifier). An interview with R401 was conducted on 2/11/26 at 4:38 PM. She was asked if she recalled the incident on 12/26/25, and R401 revealed: I was assaulted about maybe ten (10) times on the head. My glasses flew off the floor from the hit; it scared me. When asked how it happened, R401 indicated that she was on the chair asleep in the dining room (2nd floor) and all of a sudden boom, 10-12 hits on her face. I screamed for help! The man pulled me off the chair, so I fell off, and he started kicking me on the floor. No one was there until CNA P arrived and helped me. After the incident, I just wanted to be by myself in my room because I did not feel safe here. Staff doesn't make me feel safe. Did the nurse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2704522. Based on interviews and record review, the facility failed to ensure that the alleged violations involving two (2) incidents of resident-to-resident altercations for 3 residents (R401, R402, and R403) were thoroughly investigated and reported timely as required after allegations were made of three (3) residents reviewed for abuse. Findings include:*12/7/25 Incident #1: (Resident-to-resident altercation): The timeliness for this particular investigation showed that according to the Verification of Investigation Summary was completed on 2/5/26, equivalent to 60 days to be exact, from the incident of Resident-to-Resident Altercation that occurred on 12/7/2025. In conclusion: The facility acknowledges that the allegation of a physical altercation between residents was identified and taken seriously. Prompt follow-up, interviews by the administration were conducted with all parties involved. A review of the Facility Risk Management Report #1333, dated 12/7/25 at 14:45 (2:45 PM), revealed: Type of Incident: Resident-to-Resident Altercation. Incident Location: Dining Room. Nursing Description: Was informed resident was in the dining room on the first floor and was hit in the face 3 times by another resident. Resident Description: Resident was unable to give a description. Other info: Resident (R403) was in the dining room waiting for smoke break time. Writer (Nurse A) was informed that another resident (R402) hit him in the face. A review of statements pertaining to the incident on 12/7/25 revealed:On 12/7/25, Nurse A wrote: There was a page overhead for help in the downstairs Dining Room. The writer was informed that my resident (R402) was hit in the face three (3) times by another resident (R402). He was brought back to his room on the 3rd floor. DON was aware of the situation. On 12/7/25, Certified Nurse Aide (CNA B) in her statement wrote: Standing at the counter, just arrived , looked in the dining room, and Resident (R402) hit Resident (R403) in the face three (3) times. I went to stop it, and he (R402) then hit me in the face. After we separated R402 and R403, he (R402) went after another resident, B.B. Then Nurse B.J. Had a hard time assisting the resident back to the unit for safety. The facility Risk Management Report noted that the Director of Nursing (DON) was notified on 12/7/25 at 1624 (4:24 PM), approximately 2 hours after the incident occurred. CNA B, during the interview by phone conducted on 2/11/26 at approximately 7:45 AM, indicated that she witnessed R402 attack R403 in the first-floor dining room. CNA B described that she was standing at the receptionist desk when she heard yelling and saw R402 punch R403 on the face three (3) times. R402 was standing on top of R403, who was sitting in his chair. R403 was unable to fight back. CNA B quickly tried separating both and received a hard punch on her face from R402. CNA B described how strong and hard a punch was. After successfully separating residents, R402 started swinging at other residents and staff. CNA ‘B observed R403's apparent bruising on the face. When asked how R402 is like, CNA B described R402 as easily getting agitated, swearing and yelling a lot, and repeating the same words loudly. During an interview with the Director of Nursing (DON) on 2//12/26 at 12:15 PM, she stated that was aware of the resident-to-resident altercation that occurred on 12/7/25 between R402 and R403. The DON revealed that the abuse coordinator determined it was not reportable. Although staff witnessed it, R403 was unharmed and gave a thumbs-up when asked if he was okay. Abuse was not substantiated. No report to the state was necessary. Resident 403 (R403): R403 was [AGE] years old and was admitted to the facility on [DATE]. According to the Psychiatry follow-up dated 11/28/2025, his Brief Interview for Mental Status (BIMS) score is 0/15. A score of zero indicates severe cognitive impairment. Upon admission, R403 was diagnosed with Hemiplegia and Hemiparesis affecting the Right dominant side after an intracranial bleed, Major Depression and Anxiety Disorder, in addition to other diagnoses. R403 was taking paroxetine HCL 10 mg 1X (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily for mood, divalproex 250 mg delayed release 1 tablet daily (Mood stabilizer), and Seroquel 25 mg 1 tablet by mouth at bedtime. The current Administrator#2 on 2/11/26 at 2:00 PM revealed that they just recently reviewed the resident-to-resident altercation between R402 and R403. The Administrator #2 and the corporate staff on 2/11/26 both agreed that this particular incident should have been reported after a thorough investigation per the facility Abuse Policy. The past Administrator was the Abuse coordinator at that time. Resident #402 (R402): R402 was [AGE] years old admitted to the facility on [DATE]. According to the Social Service Director (SW I) dated 12/23/25, R402 had a BIMS score of 11/15. According to the Cleveland Clinic (9/9/25), a BIMS score of 11 indicates the person has mild cognitive impairment (BIMS scores range from 8-12). According to his psychiatry follow-up dated 11//28/2025, R402 was on 3 medications: recommended by pharmacy for a Gradual Dose Reduction, namely, Seroquel 100 mg tablet for Dementia with associated psychotic and or agitated behaviors, and Depakote 500 mg tablet extended release 24 hours for Mood Stabilizer, and Sertraline 100 mg tablet for antidepressant. On 2/12/25 at 1:30 PM, the facility failed to maintain follow-up records after a resident-to-resident (physical) altercation. Upon review of R403 progress notes, there were no entries in the progress notes after the incident between the dates 12/8/25 and 12/30/25. This was confirmed by the facility's corporate nurse, who was on-site on 2/12/26 at 1:39 PM. When the corporate staff was asked why there was no entry, assessments or follow-up? The Corporate staff did not respond. The Director of Nursing and Corporate Nurse at the facility, on 2/12/26 at 1:39 PM during the interview, confirmed that no documentation was entered in R403's Progress notes post-incident regarding the resident-to-resident altercation on 12/7/2025. There were no follow-up assessments by the nursing staff, physician, or nurse practitioner, and no psych referral notes were found in R403's clinical record. 12/27/25 Incident #2: Resident-to-Resident Altercation: (R401 & R402): On 1/26/26 at 2:25 PM, the facility was asked to provide the Incident Report for residents R401 and R402. The Director of Nursing submitted a thin manila folder of her risk management report. Upon review of the report dated 12/27/25, it stated: Written Statements completed and given to management. I asked the DON for copies of the written statements from staff, as noted in the statements, but she said she was unable to locate them. The timeliness for this particular investigation Incident #2 involving (R401 and R402) showed that according to the facility's Verification of Investigation Summary, was completed on 1/27/26. The facility took 31 days to complete the investigation and determine if the abuse is substantiated or not after a witnessed separated 2 residents from a Resident-to-Resident Altercation. The facility investigation concluded: that Res. #2 (R402) reported making physical contact with Res #! (R401) .In conclusion: The facility has determined that the allegation of abuse is unsubstantiated . An interview with the Second Floor Charge Nurse, conducted on 1/26/26 at 3:30 PM, who worked that weekend on 12/27/25, indicated that she received written statements from the staff regarding the resident-to-resident altercation and turned them over to management. She confirmed reading and submitting them to the DON. The DON was interviewed on 01/26/2026 at 3:30 PM and requested that the facility investigate the R401 and R402 incidents that occurred on 12/27/2025. The DON verified that she was notified by phone about the incident on 12/27/25. She explained that since it happened on the weekend, she was not present at the facility. Instead, she completed the Facility Risk Management documentation and the investigation upon her return on 1/2/2026 (7 days after the incident). The DON stated no abuse occurred, and the incident was deemed not reportable because they did not substantiate that abuse took place. Nurse's notes dated 12/27/25 at 1815 (6:15 PM) were reviewed. Nurse wrote: Resident was attacked in the day room by R402 (writer used the resident's room number as identifier). The attack was witnessed by CNA D. CNA D entered the room to inform them of the attack. CNA D stated that (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R402 entered the dayroom very angry and agitated, striking R401 in the face, knocking her glasses off. CNA D told Nurse C that R$01 is back in her room and is scared to death. The attacking resident, R402, was made to return to his room and not leave. He is currently under constant 1:1 observation to ensure the safety of residents and staff. The administrator, DON, and on-call unit manager were called. 911 called, and the police are on their way. Nurse C during an interview on 1/26/26 at 3:30 PM, Nurse confirmed she was the author of the above statement. She stated that she is an RN and was used to documenting what happened or what was reported. Nurse C was a bit uneasy because she had just received a verbal education from management before the interview with the surveyor. It was about her documentation on 12/27/25; she was told it was inaccurate, received a write-up, and was asked to sign. The surveyor asked which document was inaccurate. She said, I don't understand it either. I thought I wrote what was reported to me because I did not witness the incident. The surveyor asked whether management asked her to change/ modify, or delete what she wrote in the nurse's notes. She did not reply. On 1/26/25 at 4:00 PM, the Facility Administrator #1, who was also the abuse coordinator, was not able to provide a full investigation at the time of the request. The Administrator #1 explained that it was not substantiated and was not deemed reportable. The Abuse coordinator was asked how they analyzed and came up with the conclusion of not substantiating abuse. She stated that there was no witness that she was assaulted. The Abuse coordinator/Administrator #1 was then asked whether an alleged assault was reportable under your policy. The abuse coordinator did not respond. On 2/10/26 at 4:00 PM, DON Investigation dated 1/2/26 (no time) was reviewed. It wrote: Resident R401's (first and last name was written) was interviewed and reported that she was assaulted in the day room near the refrigerator when another resident entered the area. R401 reported that R402 (the resident's initials were written) became visibly agitated and struck her multiple times, knocking her glasses off. Staff immediately intervened upon observing the interaction and separated both residents. Police Report date d12/27/25: On 2/10/26 at 11:00 AM, A full investigation file for the 12/27/25 incident was presented to the surveyor, which included the Police report as requested. A review of the police report dated 12/27/25 at approximately 6:29 PM revealed that officer F responded to the 911 call and described that upon arrival, he interviewed the complainant (R401) stated that the assailant (R402) punched her on the face. Officer F noted in his report that he observed a slight redness on the right side of R401's face. R401 was asked by the officer if she knew why R402 punched her. R401 replied that she was not sure why R402 punched her on the face. During the interview with R402, Officer F written report revealing that R402 was described as having difficulty communicating. When Officer F asked R402 if he punched R401 on the face? R402 told the officer Yes, and then he made a motion like he balled his fist up and swung a punch. Although the police officer's report redacted some words, the officer wrote, Due to the male's (redacted words) was unable to be placed in handcuffs or lodged at jail (name of county mentioned). Reviewed Police report Case No. 2539906252 on 2/10/26 at 4:00 PM. Resident 401 (R401): R401 was [AGE] years old and admitted on [DATE] with the diagnosis of Bilateral Osteoarthritis of the knee, Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Schizophrenia, and anxiety disorder in addition to other diagnoses. According to the assessment dated [DATE], R401's BIMS score was 13/15. A score of 13-15 indicates that a person is cognitively intact. It signifies normal memory and thinking skills with little to no cognitive impairment. R401 takes Depakote 250 mg delayed-release (2 tablets at bedtime), Paxil 20 mg (1 tablet daily), Fluphenazine decanoate 25 mg/ml injection every 2 weeks, and trazodone 100 mg tablet daily. An interview with R401 was conducted on 2/11/26 at 4:38 PM. She was asked if she recalled the incident on 12/26/25, and R401 revealed: I was assaulted about maybe ten (10) times on the head. My glasses flew off the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor from the hit; it scared me. When asked how it happened, R401 indicated that she was on the chair asleep in the dining room (2nd floor) and all of a sudden boom, 10-12 hits on her face. I screamed for help! The man pulled me off the chair, so I fell off, and he started kicking me on the floor. No one was there until CNA P came to help me. After the incident, I just wanted to be by myself in my room because I did not feel safe. I was bleeding from my mouth. They found blood on my pillow and covers the next day. I think it loosened my teeth, and I saw the dentist after that. R401 told the surveyor that she was scared until R402 was finally moved upstairs to the 4th floor last week. An interview with CNA D was conducted on 2/10/26 at 3:15 PM. She indicated that on 12/27/25, she was at a resident's room feeding and heard Help! Help! Help! She came out to respond and saw R401in contact with R402. I did not see him hit her, but she was on the floor next to her chair while R402 was sitting at the edge of his wheelchair, making loud outbursts, on top of her with both of his arms in motion to strike her. I separated them immediately by pulling R402 away from R401 and locked his wheels. I then gave R401 a hand so she could go back to her chair. Since R401 was a one-transfer assist, I got her up without calling the nurse because she appeared very scared. I told the nurse what happened, and she took over. We then called 911. R401 was so scared that she did not leave her room for 2 days. That is very unusual for R401. No other staff or residents were in the dining room at the time of the incident. The nurse and other CNA was providing patient care. CNA D did not recall if R402 was placed on 1:1. CNA D said that she had a written statement, which she submitted to the floor manager. She said that she took a photo of the statement as proof if I needed it. CNA D denied being assigned to do a 1:1 bot on Saturday and Sunday. On 2/11/25 at 7:35 PM, the surveyor interviewed the third staff member who worked on the second floor on the day of the R401 and R402 altercation. Stated CNA G came to see R401 after he heard that she was attacked by R402. CNA G said that R401 expressed that she was scared. The Administrator #2 and the corporate staff on 2/11/26 both agreed that the Resident-to-Resident (physical) altercation witnessed or alleged should have been reported and taken seriously by the Abuse Coordinator (Administrator #1).On 2/12/25 at 3:00 PM, the surveyor confirmed that the facility did not report the 2 incidents of resident-to-resident altercation to the Facility Report Investigation FRI submission site. The Facility's Policy entitled The Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 11/28/2017. Abuse Policy (Page 4 of 14) revealed: It is the policy of the facility that each resident will be free from Abuse. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection.E. Investigation (page 8 of 14) It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated.G. Reporting and Response (page 11 of 14) It is the policy of this facility that 'abuse' allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the alleged violation is made.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2704522. Based on interviews and record review, the facility failed to ensure that behavioral health services were provided in a timely manner to 2 residents (R402 and R403) after a witnessed resident-to-resident (physical) altercations of three (3) residents reviewed for behavioral health follow-up assessments and services.Findings include:A review of the facility's investigation report was conducted on 2/11/26 at 3:30 pm. The report, entitled Verification of Investigation Summary for the Resident-to-Resident Incident that occurred on 12/7/25, was completed on February 5, 2026, by Administrator#1. In Conclusion: The facility acknowledges that an allegation of a physical altercation between residents was identified and taken seriously. Prompt follow-up interviews by the administrations were conducted with all parties involved. Staff Signature: Administrator#1 dated 12/25.The timeliness for this particular investigation showed that the Verification of Investigation Summary was completed on 2/5/26, equivalent to 60 days to be exact, from the incident of Resident-to-Resident Altercation that occurred on 12/7/2025. In conclusion: The facility acknowledges that the allegation of a physical altercation between residents was identified and taken seriously. Prompt follow-up, interviews by the administration were conducted with all parties involved.A review of the Facility Risk Management Report #1333, dated 12/7/25 at 14:45 (2:45 PM), revealed: Type of Incident: Resident-to-Resident Altercation. Incident Location: Dining Room. Nursing Description: Was informed resident was in the dining room on the first floor and was hit in the face 3 times by another resident. Resident Description: Resident was unable to give a description. Other info: Resident (R403) was in the dining room waiting for smoke break time. Writer (Nurse A) was informed that another resident (R402) hit him in the face.On 12/7/25, Certified Nurse Aide (CNA B) wrote: Standing at the counter, just arrived, looked in the dining room, and Resident (R402) hit Resident (R403) in the face three (3) times. I went to stop it, and he (R402) then hit me in the face. After we separated R402 and R403, he (R402) went after another resident, B.B. Then Nurse B.J. Had a hard time assisting the resident back to the unit for safety.CNA B during the interview by phone conducted on 2/11/26 at approximately 7:45 AM, indicated that she witnessed R402 attack R403 in the first-floor dining room. CNA B described that she was standing at the receptionist desk when she heard yelling and saw R402 punch R403 on the face three (3) times. R402 was standing on top of R403, who was sitting in his chair. R403 was unable to fight back. CNA B quickly tried separating both and received a hard punch on her face from R402. CNA B described how strong and hard a punch was. After successfully separating residents, R402 started swinging at other residents and staff. CNA 'B observed R403's apparent bruising on the face. When asked how R402 is like, CNA B described R402 as easily getting agitated, swearing and yelling a lot, and repeating the same words loudly.During an interview with the Director of Nursing (DON) on 2//12/26 at 12:15 PM, she stated that she was aware of the resident-to-resident altercation that occurred on 12/7/25 between R402 and R403. The DON revealed that the abuse coordinator determined it was not reportable. Although staff witnessed it, R403 was unharmed and gave a thumbs-up when asked if he was okay. Abuse was not substantiated. No report to the state was necessary.Resident 403 (R403):R403 was [AGE] years old and was admitted to the facility on [DATE]. According to the Psychiatry follow-up dated 11/28/2025, his Brief Interview for Mental Status (BIMS) score is 0/15. A score of zero indicates severe cognitive impairment. Upon admission, R403 was diagnosed with Hemiplegia and Hemiparesis affecting the Right dominant side after an intracranial bleed, Major Depression and Anxiety Disorder, in addition to other diagnoses. R403 was taking paroxetine HCL 10 mg 1X daily for mood, divalproex 250 mg delayed release 1 tablet daily (Mood stabilizer), and Seroquel 25 mg (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 tablet by mouth at bedtimeResident #402 (R402):R402 was [AGE] years old and was admitted to the facility on [DATE]. According to the Social Service Director (SW I) dated 12/23/25, R402 had a BIMS score of 11/15. According to the Cleveland Clinic (9/9/25), a BIMS score of 11 indicates the person has mild cognitive impairment (BIMS scores range from 8-12). According to his psychiatry follow-up dated 11//28/2025, R402 was on 3 medications: recommended by pharmacy for a Gradual Dose Reduction, namely, Seroquel 100 mg tablet for Dementia with associated psychotic and or agitated behaviors, and Depakote 500 mg tablet extended release 24 hours for Mood Stabilizer, and Sertraline 100 mg tablet for antidepressant.On 2/12/26 at 11:30 AM, a review of R402 and R403 clinical records was conducted. There were no follow-up progress notes, post-assault assessments, entered in the Electronic Medical Record EMR pertaining to the resident-to-resident altercation. There was no follow-up assessment after 3 blows to R403's face were received. No notes, no description as to facial redness, bruising, or discoloration. No progress notes regarding R403's physical, social, or emotional status. There was no follow-up documentation for the signs and symptoms of pain. There was no record of a post-incident assessment made by a Physician or Nurse Practitioner/physician assistant being in R403's records. There was no psych service referral, evaluation, or therapy referral performed for either resident's post-incident.According to a review of records from 12/7/25 to 12/30/25, for R403, there is no evidence that he received behavior care assessments and a psych evaluation after the incident on 12/7/25. There was no Social Services visit received either to assess if immediate psychiatric or behavioral interventions are necessary,According to the review of records from 12/7/25 to 12/30/25, for R402, there was no evidence that he received any psych eval or services post-incident. There was no Social Services documentation or visit pertaining to the post-physical altercation incident.On 2/11/26 at 3:30 PM, the SW admitted that she did not see R402 after the 12/7/25 incident with R403. His BIMS Score is 11, but we don't know what triggers him to get agitated. The surveyor asked whether he often exhibits impulsive behavior. SW I stated that it has been observed often as his baseline, and they do monitor him on the behavior log called Task Behaviors. We tried putting him on anger management, but he was not receptive to it. He is delusional, without triggers and unpredictable. SW I described R403 as a sweet person and would never initiate any violent or physical altercation. He has a BIMS of zero. R403 was not seen by behavior services after the December 7, 2025, incident. He was seen later on January 8, 2026 (1 month after the incident). When asked why it took a month for Psych Services to see him. SW I did not have an answer. SW I revealed that she did not have a progress note entry for R403 because she was unaware of the altercation or did not remember hearing about it. SW I inform her. SW I denied knowing about the referral she was supposed to schedule for SW. SW I admitted during an interview on 2/12/25 at 1:00 PM that she did not send a referral after the physical altercation. Both residents have a psychological diagnosis and are being prescribed medications for their diagnoses. Behavior care should have been alerted post-incident.A psychiatry follow-up service dated 1/8/2026 was reviewed, and it was noted that R403 was last seen on 11/28/25. There was no indication in the 4-page evaluation by a Psych Nurse Practitioner that she needed to evaluate a post-incident: resident-to-resident physical altercation that occurred on 12/7/25.A psychology follow-up for R402, dated 1/13/26, revealed that R402 was last seen in November2025, which was his most recent session before the 1/13/26 psychology follow-up. The goal of the visit was supportive psychotherapy. There was no mention of the 2 incidents of resident-to-resident altercation in the 6-page evaluation dated 1/13/26. A second visit was conducted on 1/27/26 by the Psychologist. After reviewing the 7-page visit record, there was still no mention of his aggressive behavior or the involvement of two (2) residents in a resident-to-resident altercation in December of 2025. He was not seen by the behavioral (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	health services, and there was no record of him being assessed by the facility's social worker for the entire month of December.On 2/12/26 at 1:00 PM, Social Services Director (SW I) revealed that she was unaware of the 12/7/26 altercation incident or was alerted by the interdisciplinary team. She admitted that it is her responsibility to make referrals, if necessary, for each resident, and that she is doing so by herself.The facility's Behavior Management Program Effective date: 11/28/2017 was reviewed at 2/12/26 at 1:00 PM. The Purpose of the Behavior Management Program is to promote and provide the highest practicable quality of life and safe environment for residents and staff. Guideline: This facility will maintain a strong commitment to the safety and welfare of all residents under our care .3. Conduct Behavior Management Team Meetings to include the following residents: . Residents with Reportable incidents related to behavior.Residents with behavior tat are: 1, Harmful to others.2. Interfering with function or care,