STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235705	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helen Newberry Joy Hltcu Golden Leaves Living Cent	502 West Harrie Street Newberry, MI 49868

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 0584 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to Intakes #MI00153229 and #MI00152446 Based on observation, interview, and record review, the facility failed to prevent one Resident (#3) of eight residents reviewed for homelike environment related to personal property from entering the rooms and taking personal possessions of other residents. This deficient practice resulted in Residents #2, #4, & #5 experiencing fear of continued resident to resident abuse, frustration, and emotional distress and items being taken from #7 and #8. Findings include: On 6/4/25 at 10:15 AM, the doorways to residents' room were observed with mesh-type barriers with stop sign notifications on the barriers. The barriers extended across the doorways and were secured with Velcro on each end to the doorframes. The Director of Nursing (DON) said the barriers were utilized to prevent Resident #3 (R3) from entering the rooms of other residents. Resident #2 (R2) On 6/4/25 and 6/5/25, the door to R2's room was observed with a sign indicating Do Not Enter. The door to the room was closed with a mesh barrier secured across the doorway. R2 was interviewed on 6/4/25 at 3:33 PM. R2 said the sign on the door and the barrier across the doorway was intended to prevent R3 from entering the room and taking R2's belongings. R2 said R3 constantly entered the rooms of other residents and either destroyed their belongings or removed their belongings. R2 said she was fearful of R3 due to R3 physically harming R2 by striking her in the head a couple months ago when R2 tried to prevent R3 from entering her room and taking her belongings. A progress note in R2's Electronic Medical Record (EMR), dated 4/14/25 at 3:27 PM read, in part: .Resident had an altercation with resident [R3] today. [R3] was attempting to get into resident's room. Resident then pushed her away. [R3] then went to hit resident in the right ear and made contact . A Minimum Data Set (MDS) assessment dated [DATE] documented R2 had a Brief Interview for Mental Status (BIMS - a test for cognitive status) of 15, signifying R2 was cognitively intact. The MDS indicated the short-term and long-term memory of R2 were intact, and R2 had no concern with memory or recall ability. (continued on next page)

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

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F 0584 Level of Harm - Actual harm Residents Affected - Few	An admission MDS dated [DATE] documented R2's preferences for customary routine in Section F0400.B. The question: How important is it to you to take care of your personal belongings had a documented response of being very important to R2. Resident #4 (R4) R4 was interviewed on 6/5/25 at 9:31 AM. R4 said she had difficulties with R3. When asked to provide an example, R4 said a few weeks prior she heard the resident in the next room calling out for help. She went to the room next door and observed R3 removing items from the room. R4 said she attempted to stop R3 from removing the items and R3 placed her hands around R4's neck and began choking her. R4 said the encounter shook her up. R4 said R3 entered her room on previous occasions and tried to take her personal items. R4 said R3 continually entered the rooms of other residents and took their belongings. A progress note in the EMR of R4 dated 5/18/25 at 6:35 PM read, in part: .Resident visibly shaken after (choking) [sic] altercation with resident [R3]. Resident states that she was 'trying to help.' Resident assessed for marks or bruises, none found . A progress note dated 5/18 at 7:35 PM read, in part: . She states she is nervous about going to sleep, she was reassured that she is safe. She voiced frustration .Stop sign was placed across her door . The EMR disclosed R4 was admitted to the facility 2/22/25. An admission MDS dated [DATE] documented a BIMS score of 14 indicating R4 had intact cognition. The MDS documented R4's preferences for customary routine in Section F0400.B. The question: How important is it to you to take care of your personal belongings had a documented response of being very important to R4. The most recent MDS dated [DATE] documented R4 had intact short-term and long-term memory and had no issues with memory or recall ability. Resident #5 (R5) R5 was interviewed on 6/5/25 at 9:42 AM. R5 said R3 came into her room and dumped her potted plants and began picking up her personal items. R5 said she began screaming and R4 came to the room to help by stopping R3 from taking the personal items. R5 said R3 started choking R4 so R5 started screaming again to gain staff assistance. R5 said, I'm so scared of [R3]! She got in here once and she can get in here again. She hurts people. I'm scared she's going to come in here at night when fewer people are around. A progress note in the EMR of R5 dated 5/18/25 at 6:35 PM read, in part: . Resident shaken after witnessing altercation between 2 residents. Resident states that [R3] came into her room and dumped out flowerpots and was scattering Kleenex . R5 was admitted to the facility 2/14/25. An admission MDS dated [DATE] documented a BIMS of 10 indicating R5 was moderately cognitively impaired. The MDS did not document concern with short-term or long-term memory impairment or R5's memory or recall ability. The MDS documented R5's preferences for customary routine in Section F0400.B. The question: How important is it to you to take care of your personal belongings had a documented response of being Very Important to R5. (continued on next page)

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F 0584 Level of Harm - Actual harm Residents Affected - Few	Resident #7 (R7) R7 was interviewed on 6/5/25 at 8:20 AM. R7 said R3 goes into residents' rooms and takes their things. R7 said R3 tried to enter her room previously but R7 was able to redirect R3 and deter R3 from removing items from their room. R7 was admitted to the facility 10/5/23. An annual MDS dated [DATE] documented a BIMS of 15. The MDS documented R7's preferences for customary routine in Section F0400.B. The question: How important is it to you to take care of your personal belongings had a documented response of being Somewhat Important to R7. A quarterly MDS dated [DATE] supported a BIMS of 15 and indicated R7 had no concern with short-term and long-term memory, and no concern with memory or recall ability. Resident #8 (R8) R8 was interviewed on 6/5/25 at 8:31 AM. R8 said, [R3] likes to come in my room and take my things. R8 said about a month ago, R3 entered her room and tried to take something from the room. When R8 tried to stop R3 from taking her belongings, R3 struck R8 in the head. R8 said she reported it, but nothing ever came of it aside from staff placing the barrier across the doorway of the room. R8 was admitted to the facility 8/27/24. An admission MDS dated [DATE] documented R8 was cognitively intact with a BIMS of 14. The MDS documented R8's preferences for customary routine in Section F0400.B. The question: How important is it to you to take care of your personal belongings had a documented response of being Somewhat Important to R8. An MDS dated [DATE] documented R8 had no concerns with short-term or long-term memory and had no concerns with memory or recall ability. Resident #3 (R3) An interview was attempted with R3 on 6/4/25 at approximately 11:00 AM. R3 became agitated and said, Why don't you go **** yourself! R3 was admitted to the facility 12/2/24. An MDS dated [DATE] documented a BIMS of 3, signifying R3 had severe cognitive impairment. The MDS documented R3 had behaviors including physical behaviors directed toward others, verbal behavioral symptoms directed toward others and other behavioral symptoms. The MDS coded R3 with wandering behaviors. (continued on next page)

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F 0584 Level of Harm - Actual harm Residents Affected - Few	Review of progress notes revealed 49 entries regarding R3 removing items from the rooms of other residents and/or wandering into the rooms of other residents: 12/4/24 at 11:30 PM, 12/5/24 at 12:42 AM, 12/5/24 at 8:49 PM, 12/6/24 at 8:00 PM, 12/8/24 at 5:07 PM, 12/9/24 at 1:55 AM, 12/9/24 at 10:04 PM, 12/10/24 10:12 PM, 12/12/24 at 1:11 AM, 12/13/24 at 12:54 AM, 12/14/25 at 9:16 PM, 12/22/24 at 8:34 AM, 12/25/24 at 5:56 PM, 12/30/24 at 6:42 PM, 1/6/25 at 6:46 PM, 1/10/25 at 2:35 AM, 1/1725 at 2:52 AM, 1/17/25 at 10:13 PM, 1/24/25 at 1:36 AM, 1/26/25 at 3:00 PM, 1/31/25 at 2:46 PM, 2/3/25 at 6:06 PM, 2/12/25 at 6:13 PM, 2/16/25 at 3:39 AM, 2/22/25 at 2:59 AM, 2/23/25 at 12:12 PM, 2/24/25 at 6:07 PM, 2/25/25 at 5:58 PM, 2/25/25 at 11:39 PM, 3/2/25 at 12:54 AM, 3/2/25 at 8:30 PM, 3/4/25 at 6:12 PM, 3/8/25 at 2:56 AM, 3/9/25 at 9:11 PM, 3/10/25 at 10:44 PM, 3/11/25 at 6:17 PM, 3/13/25 at 1:24 AM, 3/19/25 at 9:06 PM, 4/1/25 at 2:53 PM, 4/2/25 at 10:10 PM, 4/6/25 at 8:58 PM, 4/9/25 at 7:37 PM, 4/12/25 at 8:53 PM, 4/13/25 at 7:17 PM, 4/13/25 at 8:43 PM, 4/15/25 at 1:22 PM, 4/16/25 at 6:21 AM, 4/23/25 at 2:37 PM, and 5/18/25 at 6:35 PM. A behavior note in the EMR of R3 dated 4/13/25 at 7:17 PM read, in part: .resident is in and out of many resident rooms and is causing residents to be upset. She is taking things from residents rooms and walking out of rooms with them. She has upset a couple residents that (2) of them have swatted towards her to get out of their rooms and have yelled at her . A progress note dated 2/16/25 at 3:39 AM documented, in part: . Resident not sleeping tonight and if left by herself she goes straight into someone's room waking them, cursing them if they tell her to get out . A behavior note dated 2/12/25 at 6:13 PM documented, in part: . Resident has been wandering in/out of other residents [sic] room this shift, going through other residents [sic] belongings. Other residents are getting angry/frustrated with this resident and staff as well . A progress noted dated 1/24/25 at 1:36 AM read, Resident has been awake all night thus far. She is not sleeping and has been in and out of multiple residents' rooms and waking them up as well as startling them as it is late hours, and they are asleep. Multiple unsuccessful attempts to redirect resident. During an interview on 6/5/25 at 8:56 AM, Certified Nurse Aide (CNA) E said she witnessed R3 get verbally aggressive toward other residents, including raising her voice to them and using profanity loudly to other residents. CNA E said, Other residents [NAME] out of [R3's] way and keep their distance to try and avoid her. CNA E said it is almost impossible to keep R3 from going into other residents' rooms and taking their things because R3 wanders the halls almost constantly. Licensed Practical Nurse (LPN) G was interviewed on 6/5/25 at 10:08 AM. LPN G said R3 went into other residents' rooms at all times of the day and night. LPN G said, It's impossible to keep up with her. She [R3] takes their [other residents] things, and they [other residents] get mad. I can't blame them - I'd be mad too. LPN G said one resident threatened to hit [R3] because he was annoyed with R3 going into his room. (continued on next page)

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F 0584 Level of Harm - Actual harm Residents Affected - Few	The Director of Nursing (DON) was not available in the facility on 6/5/25. The Assistant Director of Nursing (ADON) was interviewed on 6/5/25 at 11:01 AM. When asked what was being done to keep R3 from going into residents' rooms and taking their belongings, The ADON said, I can't answer that - I don't have an answer. The ADON then said, Staff keep an eye on [R3] and get her out of residents' rooms when they see [R3] going into the rooms. When asked if residents in the facility have the right to maintain their personal possessions without fear of their possessions being destroyed or taken by another resident, the ADON replied, Yes - they absolutely have that right. The undated document issued by the Michigan Long Term Care Ombudsman Program My Rights as a Resident of a Nursing Home stated, in part: . My rights as a resident of a nursing home are guaranteed by both federal and state laws. The laws require nursing homes to promote and protect the rights of each resident and place a strong emphasis on individual dignity and choice. Living in a nursing home, I maintain all rights I had before becoming a resident of the home . I have the right to . privacy .live in a clean and safe space . Be free from verbal and physical abuse .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 deficiency pertains to Intakes #MI00152446 and #MI00153229 Based on interview and record review, the facility failed to ensure three Residents (#2, #4, and #7) of five residents reviewed for abuse were free from physical abuse by another Resident (#3) with a documented history of physical abuse of others. This deficient practice resulted in R2 and R4 experiencing fearfulness, frustration, and emotional distress, and R7 experiencing fear, pain and sustaining reddened areas on the neck after a choking event. Findings include: Two facility-reported incidents (FRI) regarding resident-to-resident altercations were reported to the state agency. #MI00152446 was reported on 4/14/25 and #MI00153229 was reported on 5/18/25. Both FRI listed Resident #3 (R3) as being involved in physical altercations with other residents. Intake #MI00152446 reported, in part: . DON [Director of Nursing] received call from RN [Registered Nurse] Supervisor that there was a resident-to-resident altercation. [Resident #2 (R2)] was sitting outside her room on her walker by her door. [R3] attempted to get into [R2] room. [R2] pushed [R3] away from door, RN Supervisor saw [R3] swing and hit [R2] in the side of head . R2 An interview was conducted with R2 on 6/4/25 at 3:33 PM. R2 said a couple of months ago she was sitting on the seat of her walker in the hallway outside her room waiting for the dining room to open. R2 said R3 tried to enter R2's room. R2 said when she tried to stop her, R3 hit her in the head with a closed hand and pulled on her arm which resulted in pain. R2 said she was afraid of R3 and feared she could be physically harmed again by R3. A progress note in R2's Electronic Medical Record (EMR), dated 4/14/25 at 3:27 PM read, in part: .Resident had an altercation with resident [R3] today. [R3] was attempting to get into resident's room. Resident then pushed her away. [R3] then went to hit resident in the right ear and made contact . A Minimum Data Set (MDS) assessment dated [DATE] documented R2 had a Brief Interview for Mental Status (BIMS - a test for cognitive status) of 15, signifying R2 was fully-cognitively intact. The MDS indicated the short-term and long-term memory of R2 were intact, and R2 had no concern with memory or recall ability. During an interview with Certified Nurse Aide (CNA) I on 6/5/25 at 11:48 AM, CNA I said he was present when R3 hit R2 in the hallway on 4/14/25. CNA I said R2 was sitting in the hallway outside her room and R3 tried to go into R2's room. R2 tried to stop R3 from entering the room and R3 hit R2. CNA I said, [R2] was pretty shaken up. CNA I said there were residents who were afraid of R3 because R3 was difficult to redirect. CNA I denied receiving resultant education after the resident altercations involving R3. When asked how staff knew what interventions to implement when R3 had increased behaviors, CNA I admitted there were no specific instructions or guidelines for staff to follow when R3 posed behavioral difficulties. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Intake #MI00153229 reported, in part: . staff members were finishing up report and heard [Resident #5 (R5)] yelling for help. [Name of nurse redacted] and both NOC [night] shift CNAs went to her room to see what was going on. Upon entering room [R3] was seen with her hands on [Resident #4 (R4)] neck. [CNA] redirected [R3] out of room. It was noted that there were flowerpots dumped out in sink and tissues scattered on floor . R4 R4 was interviewed on 6/5/25 at 9:31 AM. R4 said a few weeks prior she heard R5 screaming for help from the room next door to R4's room. R4 went to R5's room and observed R3 removing items from the room. R4 said she attempted to stop R3 from removing the items and R3 placed her hands around R4's neck and began choking her. R4 said the encounter shook her up. A progress note in the EMR of R4 dated 5/18/25 at 6:35 PM read, in part: .Resident visibly shaken after (choking) [sic] altercation with resident [R3] . A progress note in the EMR of R4 dated 5/18/25 at 7:35 PM read, in part: . She states she is nervous about going to sleep, she was reassured that she is safe. She voiced frustration .Stop sign was placed across her door . The EMR disclosed R4 was admitted to the facility 2/22/25. An admission MDS dated [DATE] documented a BIMS score of 14 indicating R4 had intact cognition. The MDS revealed R4 had intact short-term and long-term memory and had no issues with memory or recall ability. R5 R5 was interviewed on 6/5/25 at 9:42 AM. R5 confirmed the statement provided by R4. R5 said R3 came into her room and dumped her potted plants then began picking up her personal items. R5 said she began screaming and R4 came to the room to help by stopping R3 from taking the personal items. R5 said R3 started choking R4 so R5 started screaming again to gain staff assistance. R5 said, I'm so scared of [R3]! She got in here once and she can get in here again. She hurts people. I'm scared she's going to come in here at night when fewer people are around. A progress note in the EMR of R5 dated 5/18/25 at 6:35 PM read, in part: . Resident shaken after witnessing altercation between 2 residents. Resident states that [R3] came into her room and dumped out flowerpots and was scattering Kleenex . CNA H was interviewed on 6/5/25 at 11:30 AM. CNA H said she was the CNA who responded to the event with R3 choking R4. CNA H said she heard R5 yelling for help and went immediately down the hall to the room and saw R3 choking R4. CNA H said she had to remove R3's hands from around R4's neck and then removed R3 from the room. CNA H said R4 and R5 were very upset by the incident. CNA H said she did not receive staff education after the altercation. Resident #7 (R7) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R7 was interviewed on 6/5/25 at 8:20 AM. R7 said she was assaulted by R3 in the cafeteria when R3 approached her and started choking her. R7 said she had to pry R3's fingers off her neck. She said her neck hurt and she had red marks across her neck from R3's hands squeezing her neck. R7 said the attack was unprovoked. R7 said she was shocked by the incident but denied being fearful of R3. A progress note in the EMR of R3 dated 4/16/25 at 3:27 PM documented, in part: I was in the resident dining room .my back was to [R7] . I turned around and saw [R3] standing by [R7] and saying something I could not understand, but I could see the mad expression on [R3] face. I went over and told [R3] to be nice and not to touch anyone . I asked [R7] what had happened, and she stated that she had told [R3] to get away from her and then [R3] put her hands around [R7] neck . [R7] stated it hurt when [R3] squeezed her neck .I looked at [R7] neck and did see a red mark on each side of her neck. [R7] stated that she had tried to pull [R3] hands away, but it was hard to do . Activity Aide (AA) F was interviewed on 6/5/25 at 9:21 AM. AA F said R3 was aggressive with a lot of residents at certain times because R3 doesn't like to be told no and does not like to be redirected from the rooms of other residents. AA F said she was the employee in the dining room on 4/16/25 when R3 choked R7, and authored the progress note in R3's medical record on 4/16/25 at 3:27 PM. When asked regarding R7's reaction to the choking, AA F said R7's neck had reddened marks on both sides of her neck and R7 verbalized pain after the incident. AA F admitted there were residents in the facility who were afraid of R3 but said R7 told her she was not frightened of R3. AA F said she did not recall receiving education after the resident altercation. Resident #8 (R8) On 6/4/25 at 10:15 AM, the doorway to R8's room was observed with a mesh-type barrier with a stop sign notification on the barrier. The barrier extended across the doorway and was secured with Velcro on each end to attach each end of the barrier to the doorframe. R8 was interviewed on 6/5/25 at 8:31 AM. R8 said, [R3] likes to come in my room and take my things. R8 said about a month ago, R3 entered her room and tried to take something from the room. When R8 tried to stop R3 from taking her belongings, R3 hit R8 in the forehead. R8 said she reported it, but nothing ever came of it aside from staff placing the barrier across the doorway of the room. R8 denied being fearful of R3 and said she was not injured when she was struck by R3. There were no progress notes or mention in R8's EMR of R3 striking R8. On 6/5/25 at 8:40 AM, the Assistant Director of Nursing (ADON) was asked about the allegation conveyed by R8 that R3 had hit her. The ADON said nursing leadership had not been made aware of R8 saying she was hit by R3. R3 On 6/4/25 at approximately 10:15 AM, R3 was observed ambulating in the hallway. A staff member accompanied R3 with a hand around R3's arm to redirect the resident when R3 attempted to enter the rooms of other residents. An interview was attempted with R3 in her room on 6/4/25 at approximately 11:00 AM. R3 became agitated and said, Why don't you go **** yourself! (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the EMR of R3 revealed an admission date of 12/2/24. The diagnoses of R3 included a diagnosis of severe vascular dementia with agitation. The most recent MDS, dated [DATE], documented a BIMS score of 3, signifying R3 had severe cognitive impairment. The MDS documented R3 had behaviors including physical behaviors directed toward others, verbal behavioral symptoms directed toward others, wandering and other behavioral symptoms. Further review of the EMR disclosed instances of physical altercations toward other residents perpetrated by R3. A behavior note in R3's EMR on 1/31/25 at 1:09 AM documented, in part: .resident to resident .where this resident smacked other said resident across LEFT [sic] side face .both residents need to be kept away from each other as best to avoid further altercations. An Alert Note in the EMR dated 2/18/25 at 9:30 AM read: Resident approached another resident this AM and started talking to her, she then put both her hands around her neck and began choking her. The two residents had to be separated by staff. This resident was escorted to the Day Room so that she could calm down. A progress note dated 4/14/25 at 3:29 PM reported, in part: . Resident was attempting to get into [R2] room, [R2] pushed resident away. This aggravated [R3] and she hit [R2] on the right side of the head . A behavior note of 5/18/25 at 6:35 PM documented, in part: This writer heard yelling and witnessed resident with her hands around another resident's neck. Resident taken out of room by CNA x 2 and multiple attempts to redirect were unsuccessful, resident was becoming verbally aggressive and trying to enter other residents' rooms. Resident became aggressive with CNA and multiple attempts to redirect were unsuccessful, resident was becoming verbally aggressive and trying to enter other residents' rooms. Resident became aggressive with CNA. Resident currently 1 on 1 [1:1 - oversight by a dedicated caregiver] in her room A report by the facility's contracted provider of psychiatric services dated 3/28/25 documented, in part: . [R3] poses a threat to herself and others due to her behavior . During an interview on 6/5/25 at 8:56 AM, CNA E said she witnessed R3 get verbally aggressive toward other residents, including raising her voice to them and using profanity loudly to other residents. CNA E said, Other residents just [NAME] out of [R3] way and keep their distance to try and avoid her. CNA E said it was almost impossible to keep R3 from going into other residents' rooms and taking their things because R3 wandered the halls almost constantly. Licensed Practical Nurse (LPN) G was interviewed on 6/5/25 at 10:08 AM. LPN G said R3 went into other residents' rooms at all times of the day and night. LPN G said, You can't keep up with her. She [R3] takes their [other residents] things, and they [other residents] get mad. I can't blame them - I'd be mad too. LPN G said one resident threatened to hit [R3] because he was annoyed with R3 going into his room. LPN G admitted there were residents who were afraid of R3 and specifically mentioned R4 was frightened of R3. LPN G said R3 could pose a danger to other residents. LPN G said R3 only received 1:1 care a few hours a day 5 days per week and R3's behaviors were ramping up and worsening. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235705	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helen Newberry Joy Hltcu Golden Leaves Living Cent	502 West Harrie Street Newberry, MI 49868

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F 0600 Level of Harm - Actual harm Residents Affected - Few	CNA J was interviewed on 6/5/25 at 11:59 AM. CNA J said, [R3] always goes into other people's rooms and takes things. She is excessive and gets upset when we tell her she can't go into their rooms and taking their stuff. She for sure needs somebody with her all the time. CNA J said the 1:1 was not working because R3 doesn't always have 1:1 care. CNA J said R3 yelled and swore at the other residents and a lot of residents were frightened of R3. CNA J said residents appeared to cower when R3 walked near them. CNA J said, Someone would need to be with [R3] all the time to keep the residents safe. CNA J said they did not have access to specific resident-centered interventions when R3 had increased behaviors. An interview statement was provided by Confidential Employee (CE) K on 6/5/25 at a time not disclosed to protect confidentiality as requested. CE K said, The only reason [R3] is on 1:1 supervision with staff right now is because the state is here. CE K said, [R3] gets triggered just by looking at her, and asserted the residents in the facility were afraid of R3. The Director of Nursing (DON) was not available in the facility on 6/5/25. The ADON was interviewed on 6/5/25 at 11:01 AM. The ADON said she was the nurse who witnessed the altercation between R3 and R2 on 4/14/25. The ADON said she was in the hallway and witnessed R3 try to get into R2's room. When R2 pushed R3 away from the door of the room, R3 hit R2 in the head. The ADON said she ran down the hall and broke up the altercation and R3 was placed on 1:1 care. The ADON said R2 was upset and crying and a CNA sat with R2 to calm her down. The ADON was asked how R3 choked R7 in the dining room on 4/16/25 if R3 was 1:1 with personal oversight by a staff member after physically hitting R2 on 4/14/25. The ADON said she didn't know but employees who provided oversight through 1:1 were required to document resident activity on a facility form. The ADON was asked to provide the form. The ADON left the interview to obtain the form but returned and said there was no documentation and the 1:1 ended before the choking event of R7 on 4/16/25. The ADON said a care plan was developed by the DON after the choking event of R7. The care plans of R3 were reviewed with the ADON. A care plan focus dated as created and initiated 4/16/25 read: I have the potential to be physically aggressive towards other residents and staff r/t anger, dementia, history of harm to others, poor impulse control. An intervention initiated 5/19/25 read [R5] is nervous when I am around d/t [due to] verbal altercation, please keep me out of her room. Another intervention dated 5/19/25 read: I have become physically aggressive with [R4], please monitor me when I am out and about and ensure that I am not entering her room. A care plan dated 12/19/24 had a focus that read: I have a behavior problem r/t [related to] wandering and entering other residents' rooms. The care plan had an intervention dated as initiated 2/19/25 for 15-minute checks continuously. The care plan was dated as resolved 3/16/25. When the ADON was asked the reason 15-minute checks were discontinued, the ADON said she wasn't sure and said the checks were probably discontinued because they weren't working. When asked what interventions were put in place on 3/16/25 to protect the residents in the facility if the 15-minute checks weren't working, the ADON responded, I don't have an answer to that. A care plan dated 12/19/25 had a focus that read: I have an ADL self-care performance deficit r/t confusion had an intervention dated as initiated 3/1/25 that read: Keep me away from residents [R2] and [R7]. We do not get along at times. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The ADON was asked how interventions were evaluated and revised after each alleged or verified abuse occurrence. The ADON said R3's care plans were updated to keep R3 away from residents with whom R3 had altercations. The ADON was asked what was done proactively to protect all the residents in the facility from physical abuse by R3. The ADON said staff was expected to keep redirecting R3. When asked if redirection was successful in protecting the residents, the ADON said, Sometimes it is. The ADON said R3 was currently on continuous 1:1. The care plans for R3 did not document continuous 1:1, rather the care plan for physical aggression contained an intervention dated 4/16/25 that read, in part: Provide me with 1:1 during hours that I'm feeling more agitated, which is typically between 1500-2100 [3:00 PM - 9:00 PM] . The investigations submitted to the state agency (#MI00152446 and #MI00153229) were reviewed with the ADON. The investigation for #MI00152446 related to R3 hitting R2 on 4/14/25 documented, in part: .All staff have been educated on updates to care plans for both resident . The investigation for #MI00153229 regarding R3 choking R4 documented, in part: .All staff continue to be educated on behaviors and if they see any change in [R3] mood or increase wandering, they are to provide 1:1 until behaviors resolve . The ADON was asked for the education referenced in #MI00152446 and #MI00153229. An education document dated 4/16/25 was provided and reviewed. The document reflected required attendees were All Staff. There were 11 signatures on the document. The ADON was asked if 11 individuals constituted all staff. ADON said, No. When asked if there was additional documentation of all staff education, the ADON said, No. An education form dated 5/21/25 was reviewed with the ADON. The required attendees' section of the form listed LPN's and CNA's. The section of the form for participant attendance contained the signatures of six employees. The ADON was asked if the facility had a total of six LPNs and CNAs. The ADON said, No, there's a lot more than that. An employee schedule titled Long Term Care Bi-Weekly Schedule dated 5/25/25 through 6/7/25 contained the names of licensed nurses and CNAs in the facility. The ADON confirmed all nurses and CNAs employed by the facility were listed on the schedule. There were a total of 27 nurses and CNAs listed as current employees excluding the DON and ADON. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The policy titled Abuse Policy dated as revised 6/1/24 documented, in part: . Each resident has the right to be free from all types of abuse . The [name of facility redacted] has a great interest in protecting residents and patients from abuse, neglect, exploitation, misappropriation or mistreatment no matter who is responsible for the harm . The [facility] is responsible for protecting all residents from nonemployees whenever it has or should have reasonably had a warning of the potential problem . All employees will be trained through orientation and on-going sessions on issues related to abuse prohibition practices such as: i. appropriate interventions to deal with aggressive and/or catastrophic reactions of residents . The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation is more likely to occur. i. Including an analysis of . 4. the assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms .