STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235016	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Jackson	434 W North Street Jackson, MI 49202

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains To Intake 3020595 Based on observation, interview and record review the facility failed to ensure that grievances were documented, investigated, tracked and resolved for one Resident (#14) of three reviewed. Findings include:Resident #14 (R14)Review of the clinical record, including the Minimum Data Set (MDS) reflected R14 was admitted to the facility for short term rehab on 11/14/25 with diagnoses that included cellulitis. R14 scored 12 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Further review of the clinical record reflected R14 was discharged home on [DATE]. On 5/27/26 at 12:00 PM, during a phone interview with R14's Family Member (FM) E it was reported R14's eyeglasses went through the laundry and were broken in December 2025. FM E said it was reported at the time, the facility told FM E the family would be reimbursed, and as of 5/27/26 R14 still had not been reimbursed. Review of the facility grievance log for November 2025 to May 2026 did not reveal any concerns related to R14's eyeglasses being broken or missing. Review of an email thread initially dated 12/04/2025 revealed R14's FM E contacting Admissions Director (AD) C about R14's missing eyeglasses. AD C responded via email on 12/04/2025 and stated the Nursing Home Administrator (NHA) A was made aware and they will attempt locate the missing eyeglasses tomorrow (12/05/2025). The next email in the thread was dated 12/08/25, initiated by FM E to AD C and reflected the following:As you know, her eyeglasses were found in the laundry but were damaged. One lens is gone and the frames were partially melted. I have attached an estimate for the replacement glasses. The estimate includes all of the features her glasses had. I also had them run them through her insurance so it does include their partial payment as well. I need to get these ordered for her ASAP and they require at least 50% deposit. I don't know what your procedure is for paying for the replacement so please let me know. The next email in the chain was dated 12/16/25 initiated by Family member E to AD C and Business Office manager (BOM) D the email voiced concern from FM E indicating she had not gotten any response to the email she sent on 12/08/2025. AD C responded via email on 12/16/25, stating she had spoken with NHA A and a reimbursement check was to be sent. The next correspondence via email was dated 1/23/26 to both AD C and BOM D from FM E who provided a receipt for R14's missing glasses in the amount of $496.00 and requested R14 to be reimbursed immediately. There was no response to FM E's email from either AD C or BOM D. The next correspondence via email was dated 4/09/26 to both AD C and BOM D from FM E and stated R14 still had not been reimbursed from the facility for the broken eyeglasses and was yet again requesting to be reimbursed as promised. BOM D responded via email on 04/09/26 The information has been sent to the Administrator for follow-up, as the receipt for the eye glasses to be reimbursed was given to Administration for processing on 1/23/26.On 5/27/26 at 12:30pm, during an interview with AD C she reported she was aware R14's glasses went through the facility laundry and were broken. AD C said she was just the go between and forwarded every email from FM E to NHA A. AD C stated she had no ability to cut a check to anyone which was why she always forwarded FM E's emails to NHA A. On 5/27/26 at 12:35 PM during an interview with NHA A she stated being aware of R14's broken glasses and the facility was not required to reimburse (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14/FM E at all. When queried why R14's concern was not on the facility grievance log, NHA A stated she didn't have an answer but was positive a grievance form was filed. A copy of the grievance was requested at that time. When quired why she did not follow up with R14's family member, NHA A stated she thought corporate wrote the check, when queried if she followed up with the corporate office to ensure the check was written particularly after the April 9th email from Family Member E NHA A stated she would be following up with it today. ON 5/27/26 at 2:00 pm, during a follow up interview with NHA A she reported she was unable to locate any grievance/concern form that involved R14.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their abuse policy and procedure for one Resident (#7) of one resident reviewed for alleged abuse.Findings Include:Resident #7 (R7)Review of the medical record reflected R7 was initially admitted to the facility on [DATE] through 05/01/2026 with diagnoses including displaced comminuted fracture of shaft of right femur, subsequent encounter for closed fracture with routine healing, epilepsy, diabetes mellitus type 2, symptoms involving the musculoskeletal system, and surgical aftercare.The most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/01/2026 revealed R7 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0103, Activities of Daily Living (ADL) Assistance, R7 required maximum assist to dependent on personal care and used a wheelchair as an assistive device.During an interview on 05/20/2026 at 11:30 am, Certified Nursing Assistant (CNA) M stated she was told not to go back into R7's room by Licensed Practical Nurse (LPN) J, didn't tell her why, and she never asked. The day before she answered R7's call light, she wanted some water and she took it to her. CNA M stated she was never assigned to R7 and never provided care.During an interview on 05/20/2026 at 11:38AM, Director of Nursing (DON) B stated she was shocked R7 left the facility, stated she tried to address their issues as they were leaving the facility and R7's husband said no. R7 agreed to let DON B get a medication list. However, R7 and her family left the parking lot before she returned with a medication list and form for them to sign indicating R7 would be leaving against medical advice.During an interview on 05/20/2026 at 12:35pm, R7 stated she had a complaint, she had asked to use the bed pan and needed help getting off. R7 rang the call light for help getting off the bed pan, CNA M stated, Oh hell no You are on rehab, you can do this yourself. R7 stated CNA O heard the conversation from the hallway and told R7 to file a complaint. R7 stated she told Registered Nurse Q and she informed Nursing Administration Registered Nurse P who told R7 she would be back to address her concerns after her meeting.During an interview on 05/20/2026 at 12:56pm- LPN N stated R7 told her she was upset, she had an issue with a CNA earlier and someone was supposed to go talk to her and they did not. LPN N stated R7 told her she was leaving and then next thing she knew, 2 men came in and R7 was leaving the facility.Record review revealed R7 was admitted to the hospital with a fracture that took place at her home, had surgery and came to this facility for short term rehab on 04/28/2026 and left the faciity on [DATE]. R7 left against medical advice (AMA) after voicing concerns and someone was supposed to come up and talk to her about her concerns but never did. R7 had 2 men/family members come in and assisted her out of the facility.During an interview on 05/20/2026 at 1:05pm, CNA O stated she was in the hallway and heard the conversation between R7 and CNA M. CNA O stated R7 put on her call light, CNA M answered the call light and when R7 asked to be taken off the bed pan, CNA M told R7 Oh hell no, you can walk you can get up and do it yourself. and left her room. CNA O then went into R7's room and took her off the bed pan. CNA O stated this was brought to the nurses, and management, but was not sure who was supposed to follow up on it.During an interview on 05/20/2026 at 1:25pm, CNA M stated when R7 got to the facility, she used a walker and could pivot to go to the bathroom. CNA M denied having a conversation with R7 saying, Oh hell no! you can walk you can get up and do it yourself. CNA M raised her voice and stated I did not put her on the bedpan, and I didn't take her off the bed pan! CNA M stated Nursing Administration RN P told CNA M not to go in her room. CNA M stated the following day, Nursing Administration RN P made R7 cares in pairs. CNA M then stated the only time she answered her call light was for a glass of water, the other 2 times was an accident.During an interview on 05/20/2026 at 1:47pm, Nursing Administration RN P stated she remembered R7 due to the short time she was here. RN P stated her and DON B tried to talk to R7 on the day she was leaving the facility when two men came to picked her up. RN P stated her first interaction was a day or so before, and stated R7 wanted to talk to her but she could not remember (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what it was about. This Surveyor asked about cares in pairs and if you have a resident that is saying something about the CNA or nurse, would you not make time to talk to her? RN P stated she went into talk to R7 and introduce herself, but was headed to a meeting. RN P stated they asked R7 if they could wait to talk to RN P regarding any concerns. When this Surveyor indicated there must have been an issue to put R7 on cares in pairs, no answer was provided.When asked why CNA M stated you (RN P) told her not to go into R7's room because of an issue voiced from the resident. RN P stated she was really struggling to recall the details, then stated if CNA M said she told her that, then she must have said it. RN P stated she didn't speak long enough to R7 to know what the issue was. RN P then stated she was sure the nurse working on the floor knew about the issue, again writer asked why nothing was done about it or followed up on it. Writer asked RN P how many people knew there was an issue between R7 and CNA M and nobody did anything about it? When RN P was asked why nobody reported or investigated an allegation of abuse when RN P had instructed CNA M not to go in her room because of an issue, revised the care plan to have cares in pairs, had asked to speak to management regarding R7's complaint/concerns, and multiple staff knew about this incident, RN P stated she didn't know.During an interview on 05/20/2026 at 2:20pm, CNA O was asked when there is an allegation of abuse, what would you do? CNA O stated report it to the floor nurse, nursing manager, DON B, or Administrator A.During an interview on 05/20/2026 at 2:48pm, midnight shift RN Q, stated she remembered R7, stated R7 wasn't happy here, she had an issue with a CNA, R7 didn't want them to take care of her. RN Q told R7 she was sorry she had that experience with the CNA. RN Q told R7 she would look into this situation and told day shift nurses what was going on. Writer asked what their abuse policy instructs them to do and RN Q indicated they believed they talked to the people they were supposed to. RN Q stated she told the day shift nurses to follow up on this and the day shift nurses told her management already knew and it was taken care of.During an interview on 05/20/2026 at 3:00pm, RN P stated she talked to DON B and stated she couldn't get logged into her computer so DON B wrote a progress note regarding R7 leaving AMA. RN P stated she asked R7 if it was urgent or could their concern wait until after the meeting and R7 told her it could wait. After the meeting, RN P and DON B were told R7 was leaving the facility AMA. RN P stated there were some allegations made by R7. Writer asked RN P when she found this out and stated she needed to log into PCC to read it. RN P stated nurses that day were LPN J and LPN N, who put the buddy system in place.During an interview on 05/20/2026 at 3:28pm, Minimal Data Set (MDS) nurse R, looking at R7's care plan, was asked why the cares in pairs was put into place. MDS nurse R stated the care plan was revised by DON B and made R7 cares in pairs on 04/30/26. MDS nurse R stated she added the same interventions on 04/30/26.Record review revealed no nursing progress note noting behaviors or reason for adding cares in pairs to the care plan.During an interview on 05/20/2026 at 3:45pm, DON B stated she forgot she wrote up a risk management note, about this resident. DON B stated the business office manager (BOM) D reported to her R7 complained of not getting water and her needs were not getting met. Writer asked where the progress note was from BOM D with this information. DON B stated BOM D did not write a note or document in PCC, but gave a verbal report to DON B.Writer asked DON B why nobody investigated or reported R7's allegation of abuse and yet a CNA was instructed not to go in R7's room because of an issue, the care plan was revised to make R7 cares in pairs on 04/30/2026, R7 had asked to speak to management regarding her complaint/concerns, multiple nursing staff and administrative staff knew about the allegation, nobody attempted to talk to her until she was walking out of the facility AMA, and nothing was done to identify and possible resolve her concerns and complaints. DON B stated she didn't know.During an interview on 05/20/2026 at 4:00pm, writer reported abuse allegation to Licensed Nursing Home Administrator (LNHA) A and DON B.

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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** Based off interviews and record review the facility failed to report alleged abuse for one Resident (#7) of one reviewed for alleged abuse.Findings IncludeResident #7 (R7)Review of the medical record reflected R7 was an initial admission to the facility on [DATE] through 05/01/2026. Diagnoses of displaced comminuted fracture of shaft of right femur, subsequent encounter for closed fracture with routine healing, epilepsy, Diabetes Mellitus 2, symptoms involving the musculoskeletal system, surgical aftercare.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/2026 revealed R7 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0103, Activities of Daily Living (ADL) Assistance reveals R7 was maximum assist to dependent on personal care and used a wheelchair as an assistive device.During an interview on 05/20/2026 at 11:30 am, Certified Nursing Assistant (CNA) M stated she was told not to go back in R7's room by Licensed Practical Nurse (LPN) J, didn't tell her why, and she never asked. The day before she answered R7's call light, she wanted some water and she took it to her. CNA M stated she was never assigned to R7 and never provided care.During an interview on 05/20/2026 at 11:38AM, Director of Nursing (DON) B stated she was shocked R7 left the facility, stated she tried to address their issues as they were leaving the facility and R7's husband said no, R7 agreed to let DON B get a medication list and R7 and her family left the parking lot before she returned with medication list and leaving against medical advice form.During an interview on 05/20/2026 at 12:35pm, R7 stated she had a complaint, she had asked to use the bed pan and needed help getting off. R7 rang the call light for help getting off the bed pan, CNA M stated, Oh hell no You are on rehab, you can do this yourself. R7 stated CNA O heard the conversation from the hallway and told R7 to file a complaint. R7 stated she told Registered Nurse Q and she informed Nursing Administration Registered Nurse P who told R7 she would be back to address her concerns after her meeting.During an interview on 05/20/2026 at 12:56pm- LPN N stated R7 told her she was upset, she had an issue with an CNA earlier and someone was supposed to go talk to her and they did not. LPN N stated R7 told her she was leaving and then next thing she knew, 2 men came in and R7 was leaving the facility.Record review revealed R7 was admitted to the hospital with a fracture that took place at her home, had surgery and came to this facility for short term rehab on 04/28/2026 and left the faciity on [DATE]. R7 left against medical advice (AMA) after voicing concerns and someone was supposed to come up and talk to her about her concerns but never did. R7 had 2 men/family members come in and assisted her out of the facility.During an interview on 05/20/2026 at 1:05pm, CNA O stated she was in the hallway and heard the conversation between R7 and CNA M. CNA O stated R7 put on her call light, CNA M answered the call light and when R7 asked to be taken off the bed pan, CNA M told R7 Oh hell no, you can walk you can get up and do it yourself. and left her room. CNA O then went into R7's room and took her off the bed pan. CNA O stated this was brought to the nurses, management, but not sure who was supposed to follow up on it.During an interview on 05/20/2026 at 1:25pm, CNA M stated when R7 got to the facility, she used a walker and can pivot to go to the bathroom. CNA M denied having a conversation with the R7 saying, Oh hell no! you can walk you can get up and do it yourself. CNA M raised her voice and stated I did not put her on the bedpan, and I didn't take her off the bed pan! CNA M stated Nursing Administration RN P told CNA M not to go in her room. CNA M stated the following day, stated Nursing Administration RN P made R7 cares in pairs. CNA M then stated the only time she answered her call light was for a glass of water, the other 2 times was an accident.During an interview on 05/20/2026 at 1:47pm, Nursing Administration RN P stated she remembered R7 due to the short time she was here. Stated her and DON B tried to talk to them on the day she was leaving the facility when two men came to picked her up. Nursing Administration RN P stated her first interaction was a day or so before, stated R7 wanted to talk to her but she could not remember what (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 3017894 and 2963604 Based on interview and record review the facility failed to thoroughly investigate an injury of unknown source for one Resident (#3) and failed to thoroughly investigate an allegation of verbal abuse for one Resident (#7) from a total of three residents reviewed for abuse. Findings include:Resident #3 (R3) Review of the clinical record including the Minimum Data Set (MDS) dated [DATE] revealed Resident #3 (R3) was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, dementia and depression. R3 scored 7 out of 15 (severe cognitive impairment). Of note, R3 expired on [DATE]. Review of the Kardex (a care guide for staff) on [DATE] require two staff for bed mobility and repositioning. Review of the incident reported dated [DATE], it reflected that Certified Nursing Assistant (CNA) H reported to License Practical Nurse (LPN) F on [DATE] after the first bed check that while repositioning R3 she heard a Popping sound. The report further indicated CNA H was to use a draw sheet and ask for assistance from LPN F for any additional repositioning. LPN F found no abnormalities during the assessment of R3 but did administer two Tylenol due to R3's complaint of pain. Review of the facility reported incident dated [DATE] reflected an undated timeline of events that included an x-ray was ordered and identified a proximal fracture. Hospital recommendation was conservative management with a sling Review of a witness statement dated [DATE] conducted via phone with CNA H and signed by Nursing Home Administrator (NHA) A revealed R3 complained of shoulder pain to CNA H at approximately 8:00 pm On Monday ([DATE]th?). The statement further reflected CNA H informed LPN J at that time. The statement further stated that later that night CNA H and CNA G provided a brief change and R3 was moaning and then reported R3 complaints of pain to LPN F. Review of CNA G written statement dated [DATE] conducted via phone, signed by NHA A reflected CNA G acknowledged providing care with CNA H and R3 complained of pain. The written statement dated [DATE] conducted with LPN F (it is not clear who conducted the interview with LPN F) reflected CNA H informed LPN F had complaints of shoulder pain, an assessment was completed and with no abnormal findings and pain medication was administered. Of note, there was no written statement from LPN J or any other staff working on [DATE]. The written statement conducted with R3 signed by NHA A on [DATE] revealed R3 reported she was unable to identify staff by name, but usually had two CNA's provide care, but one unidentified CNA provided care despite R3 stating she was not feel safe with CNA changing her alone, but the CNA proceeded anyway and The girl grabbed her arm while rolling her in bed and her shoulder hurt really bad. resident reported that she and the girl heard it pop. She reported that she yelled in pain and started crying. The statement went on to say that the CNA apologized. Review of hospital records dated [DATE] reflected R3 reported to them Someone recently jerked her by her right arm, pain since. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple attempts to contact CNA H via phone call and text messages throughout the day on 5/27 and 5/28 were not responded to. On [DATE] at 9:40 am during a phone interview with CNA G, it was reported that she was working on a different floor and unit until midnight [DATE] and when she arrived on the floor where R3 resided she was informed by LPN F and CNA H that R3 had shoulder pain. On [DATE] at 9:55am during a phone interview with LPN F he reported that CNA H reported that R3 complained of shoulder pain and there was a pop LPN F stated this was most likely between 8:00 and 10:00 pm. LPN F stated the CNA's at the facility routinely change and transfer residents that are 2 person assist by themselves. LPN F stated CNA H rolled R3 alone and she should've waited for another CNA or a nurse for help. On [DATE] at 10:50 am during a phone interview with LPN J she reported a CNA (not sure which one or when) reported that R3 complained of shoulder pain. LPN J stated she was not sure why she didn't give a statement as she was the nurse assigned to R3, but that R3 was always complaining of some type of pain. On [DATE] at 2:00 pm during an interview with NHA A she reported being the facility's abuse coordinator and was ultimately responsible for investigations and reporting. she did not substantiate abuse or have any other concerns with the findings of the investigation and that when the pop was heard it was during care provided by CNA G and CNA H, and that the fracture was deemed as Pathological by the hospital. When queried if NHA A was aware the original report of shoulder pain and was 8:00 PM and CNA G was working a different floor and reported not having any contact with R3 until midnight. NHA A stated that was not aware of that. Resident #7 (R7) Review of the medical record reflected R7 was an initial admission to the facility on [DATE] through [DATE]. Diagnoses of displaced comminuted fracture of shaft of right femur, subsequent encounter for closed fracture with routine healing, epilepsy, Diabetes Mellitus 2, symptoms involving the musculoskeletal system, surgical aftercare. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] revealed R7 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0103, Activities of Daily Living (ADL) Assistance reveals R7 was maximum assist to dependent on personal care and used a wheelchair as an assistive device. During an interview on [DATE] at 11:30 am, Certified Nursing Assistant (CNA) M stated she was told not to go back in R7's room by Licensed Practical Nurse (LPN) J, didn't tell her why, and she never asked. The day before she answered R7's call light, she wanted some water and she took it to her. CNA M stated she was never assigned to R7 and never provided care. During an interview on [DATE] at 11:38AM, Director of Nursing (DON) B stated she was shocked R7 left the facility, stated she tried to address their issues as they were leaving the facility and R7's husband said no, R7 agreed to let DON B get a medication list and R7 and her family left the parking lot before she returned with medication list and leaving against medical advice form. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:35pm, R7 stated she had a complaint, she had asked to use the bed pan and needed help getting off. R7 rang the call light for help getting off the bed pan, CNA M stated, Oh hell no You are on rehab, you can do this yourself. R7 stated CNA O heard the conversation from the hallway and told R7 to file a complaint. R7 stated she told Registered Nurse Q and she informed Nursing Administration Registered Nurse P who told R7 she would be back to address her concerns after her meeting. During an interview on [DATE] at 12:56pm- LPN N stated R7 told her she was upset, she had an issue with an CNA earlier and someone was supposed to go talk to her and they did not. LPN N stated R7 told her she was leaving and then next thing she knew, 2 men came in and R7 was leaving the facility. Record review revealed R7 was admitted to the hospital with a fracture that took place at her home, had surgery and came to this facility for short term rehab on [DATE] and left the faciity on [DATE]. R7 left against medical advice (AMA) after voicing concerns and someone was supposed to come up and talk to her about her concerns but never did. R7 had 2 men/family members come in and assisted her out of the facility. During an interview on [DATE] at 1:05pm, CNA O stated she was in the hallway and heard the conversation between R7 and CNA M. CNA O stated R7 put on her call light, CNA M answered the call light and when R7 asked to be taken off the bed pan, CNA M told R7 Oh hell no, you can walk you can get up and do it yourself. and left her room. CNA O then went into R7's room and took her off the bed pan. CNA O stated this was brought to the nurses, management, but not sure who was supposed to follow up on it. During an interview on [DATE] at 1:25pm, CNA M stated when R7 got to the facility, she used a walker and can pivot to go to the bathroom. CNA M denied having a conversation with the R7 saying, Oh hell no! you can walk you can get up and do it yourself. CNA M raised her voice and stated I did not put her on the bedpan, and I didn't take her off the bed pan! CNA M stated Nursing Administration RN P told CNA M not to go in her room. CNA M stated the following day, stated Nursing Administration RN P made R7 cares in pairs. CNA M then stated the only time she answered her call light was for a glass of water, the other 2 times was an accident. During an interview on [DATE] at 1:47pm, Nursing Administration RN P stated she remembered R7 due to the short time she was here. Stated her and DON B tried to talk to them on the day she was leaving the facility when two men came to picked her up. Nursing Administration RN P stated her first interaction was a day or so before, stated R7 wanted to talk to her but she could not remember what it was about. Writer asked about cares in pairs, If you have a resident that is saying something about the CNA or nurse, would you not make time to talk to her? Nursing Administration RN P stated she went into talk to her, introduce herself, was headed to a meeting, asked the resident if she could wait to talk to her regarding any concerns. Writer stated there must have been an issue to put on cares in pairs. Asked why CNA M said that you, the Nursing Administration RN P told her not to go into R7's room because of an issue voiced from the resident. Nursing Administration RN P stated she was really struggling to recall the details, then stated if CNA M said she told her that, then she must have said it. Nursing Administration RN P stated she didn't speak long enough to R7 to know what the issue was. Nursing Administration RN P then stated she was sure the nurse working on the floor knew about the issue, again writer asked why nothing was done about it or followed up on it. Writer asked Nursing Administration RN P how many people knew there was an issue between R7 and CNA M and nobody (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did anything about it? Writer asked Nursing Administration RN P how a resident admitted to the facility on [DATE] through [DATE], instructed a CNA M to not go in her room because of an issue, revise the care plan to have cares in pairs, R7 asked to speak to management regarding her complaint/concerns, multiple staff knew about this and nobody reported it or investigated it. Nursing Administration RN P stated she didn't know. During an interview on [DATE] at 2:20pm, CNA O was asked when there is an allegation of abuse, what would you do? CNA O stated report it to the floor nurse, nursing manager, DON B, or Administrator A. During an interview on [DATE] at 2:48pm, midnight shift RN Q, stated she remembered R7, stated R7 wasn't happy here, she had an issue with a CNA, R7 didn't want her to take care of her. Midnight shift RN Q told R7 she was sorry that she had that experience with CNA, Midnight shift RN Q told R7 she would look into this situation and told day shift nurses what was going on. Writer asked what their abuse policy instructs them to do, stated she believed she did that, she talked to the people she was supposed to, Midnight shift RN Q stated she told the day shift nurses to follow up on this and the day shift nurses told her that management already knew and it was taken care of. During an interview on [DATE] at 3:00pm, Nursing Administration RN P stated she talked to DON B, stated she couldn't get logged into her computer so DON B wrote a progress note regarding R7 leaving AMA, stated she asked R7 if it was urgent or could wait until after the meeting, R7 told her it could wait. After the meeting, Nursing Administration RN and DON B were told R7 was leaving the facility AMA. Nursing Administration RN P stated there were some allegations made by R7. Writer asked Nursing Administration RN P when she found this out, stated she needed to log into PCC to read it. Writer waiting for her to get into her computer. Nursing Administration RN P stated nurses that day were LPN J and LPN N, who put the buddy system in place. During an interview on 05/2026 at 3:28pm, Minimal Data Set (MDS) nurse R, looking at R7's care plan, writer asked why the cares in pairs was put into place. MDS nurse R stated the care plan revised by DON B made R7 cares in pairs on [DATE]. MDS nurse R stated she added the same interventions on [DATE]. Record review revealed no nursing progress note noting behaviors or reason for adding cares in pairs to the care plan. During an interview on [DATE] at 3:45pm, DON B stated she forgot that she wrote up a risk management note, about this resident. DON B stated the business office manager (BOM) D reported to her that resident complained of not getting water and her needs were not getting met. Writer asked where the progress note was from the BOM D with this information. DON B stated BOM D did not write a note or documents in PCC, gave a verbal report to DON B. Writer asked DON B how a resident, admitted to the facility on [DATE] through [DATE], instructed a CNA to not go in R7's room because of an issue, revised the care plan to make R7 cares in pairs on [DATE], R7 asked to speak to management regarding her complaint/concerns, multiple nursing staff and administrative staff knew about this and nobody attempted to talk to her until she was walking out of the facility AMA, nothing was done to identify and possible resolve her concerns and complaints, nobody investigated it, nor reported it. DON B stated she didn't know. During an interview on [DATE] at 4:00pm, writer reported abuse allegation to LNHA A and DON B.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to complete wound care as directed by physician orders for two Residents (#10 & #13) of three residents reviewed. Findings include:Resident #10 (R10)On 5/21/26 at 12:25 PM, R10 was observed sitting up in his wheelchair. R10 confirmed he had a wound on his butt which was supposed to be changed every day but had not been changed for 2-3 days. A review of the clinical record revealed R10 was admitted into the facility on 2/3/19 with diagnoses that included: chronic kidney disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R10 scored 14/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).On 5/27/26 at 1:32 PM, R10's wound care dressings were observed with LPN J. LPN J reported that all 3 dressings had been changed that day, however none of the dressings were dated. All 3 (right and left hip, and coccyx) were observed to be covered with a boarder foam dressing which were observed to be clean, dry and intact. R10 confirmed that the dressings had been changed that day. LPN J reported that she would normally include a date on the dressings but couldn't find a marker that day.A review of R10's progress notes revealed the following notes from Wound Nurse Practitioner (Wound NP) S:5/14/26 .(R10-name redacted) is seen today to follow up on multiple pressure related wounds.He has been tolerating wound care well. Pressure relieving interventions in place.Debridement performed due to presence of necrotic tissue on wound bed and periwound on initial assessment to promote wound healing, and reduce risk for infection.Please be warned-wound care must be done regularly.4/30/26 Discussed dressing orders adherence with nursing.4/23/26 Please review dressing types and application with staff.Continues to be on hospice care.Resident #13 (R13)05/21/2026 11:51 AM, during an interview with R13, he reported that he had a current wound to his left foot. R13 further reported that the dressing is ordered to be changed every day and that had not been being completed but instead it was being done when they get around to it which he reported was about every 2 days.A review of the clinical record revealed R13 was admitted into the facility on [DATE] with diagnoses that included: Type 2 Diabetes, peripheral vascular disease and acute osteomyelitis, right ankle and foot. According to the Minimum Data Set (MDS) assessment dated [DATE], R13 scored 12/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition).On 5/27/26 at 1:32 PM, an observation of R13's wound dressing was completed with RN K. Dressing was observed to be clean, dry and intact (covered with rolled gauze). No date was observed on the dressing. RN K reported that she would typically date each dressing and that she had completed it that same day.A review of R13's progress notes revealed the following notes from Wound Nurse Practitioner (Wound NP) S:5/21/26 .No blue foam noted on initial assessment.Plan: Chart reviewed. Patient evaluated. Blue foam over wound bed. Cover with bordered dressing.Staff stated that there were no blue foam available-patient gets supplies from (vendor name redacted). Bag of supplies including blue foam and cover dressing noted on patients night stand.4/30/26 He reports that outer dressing was changed yesterday but has not been changed since last week with provider visit.Dressing in place very saturated with dried drainage. Outer dressing changed yesterday per patient.Dressings must be changed regularly. Readdressed with nursing.4/23/26 Dressings must be changed regularly. Address with nursing.4/16/26 Dressing dated 4/9/26.Dressings must be changed regularly. Address with nursing.3/26/26 He is unsure if wound care had been performed in the past week.Discussed care with unit manager/nursing. I will have nursing leadership review importance of adhering to wound care orders. Dressing has not been changed in one week.On 5/28/26 at 10:01 AM, during an interview with Wound NP S it was reported that he is from an outside service that rounds in the facility once per week on residents identified by the facility as needing wound care. Wound NP S reported that he rounds with Nursing Administration P. When asked how wound care is going for R10, Wound NP S reported that he had been seeing him for about a year, R10 had previously been on Hospice services so the care had been more conservative. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10 came off of hospice a few months ago and stated that his preference was for his wound care to be managed in house. Specifically, he reported that R10's wound to his sacrum had been pretty stable for about 3 months but had been improving, in December/January it had been close to being healed but developed some tunneling. When asked if there are any concerns with in house wound care, Wound NP S reported that there are times when wound care had not been performed or not performed as per the order. When asked if he had observed wound care dressings that weren't dated, he reported on occasion and that his concern was when he would observe a date on the dressing and it wasn't the date that he expected it to be (indicating the dressing had not been changed as often as ordered). Wound NP S reported that both R10 and R13 should have wound care completed daily. When asked about R13, Wound NP S reported that he had been treating a wound to his left heel for a couple of months and healing is going slow. When asked if there are any concerns with wound care being performed in house, Wound NP S reported there had been a few times when wound care had not been done and that the resident is able to report when it's completed and when it is not. Wound NP S reported that his documentation in the electronic medical record reflected his observations of wound care not being completed by in house staff and that sometimes the dressing he observes is the same dressing that he had applied the week prior (indicating it had not been changed by floor staff for an entire week). Wound NP S reported that he will typically report that to whoever he is rounding with, which is typically Nursing Administration P. Wound NP S further reported that staff had mentioned running out of dressings, specifically blue foam. On 5/28/26 at 12:54 PM, during an interview with Nursing Administration P, it was confirmed that she rounds weekly with Wound NP S, she takes the photos and Wound NP S performs the assessments. When asked if any audits are done to confirm completion of daily wound care, Nursing Administration P reported that none were completed outside of the weekly rounds that she completes with the Wound NP and no ongoing or widespread education on wound care had been done upon being notified of wound care not being completed for an entire week. When asked what the expectation is for dating the wound care dressings, Nursing Administration P reported she would like to see the date, time and nurses initials. When asked what she was aware of regarding wound care not being completed, she reported that once or twice in the past Wound NP S had reported wound care not being completed and that one on one education was done with the nurse identified as not completing it. When asked about the facility not having necessary wound care supplies, Nursing Administration P reported she felt the issue was the treatment cart needed to be organized. When asked specifically about the blue foam, she reported that it's at the bottom of the cart and the staff don't really dig for it.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent an avoidable fall for one Resident (#2) of three residents reviewed. Findings include:Resident #2 (R2)On 5/20/26 at 3:05 PM, R2 was observed lying in bed on her back and reported feeling sore with specific reports of pain in her right hip. R2 did not recall details of a fall.A review of the clinical record revealed R2 was admitted into the facility on 3/4/21 with diagnoses that included: catatonic schizophrenia and vascular dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R2 scored 8/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition).A review of an incident report for R2 dated 1/19/26, revealed the following: Pt (patient) was observed laying on her right side. Pt complaining of pain of the head and her right arm. Ambulance notified and pt was sent to ER (Emergency Room) for evaluation. In the Notes section dated 1/20/26 it was documented IDT (Interdisciplinary Team) team met to review residents fall, root cause analysis residents' bed was not extended to proper size, resident rolled out of bed due to mattress hanging over edge, ongoing investigation, intervention placed to check that resident's bed is properly positioned when in bed, education provided to staff, care plan updated on expandable bed.On 5/27/26 at 1:25 PM, during an interview with RN K, when asked if she recalled the details of R2's fall in January 2026, she reported R2 had rolled out of bed, which was observed by CNA (certified nursing assistant) L who was on the other side of the room at the time. RN K reported it was determined that the mattress was too wide for the bed frame and she believed the mattress/bed frame had been placed in the room the day before the fall but was unsure who was responsible for placing the mattress/bed frame in the room without it being properly fitted.On 5/27/26 at 1:51 PM, during an interview with CNA L, when asked what details he recalled from R2's January fall, he reported, he and another CNA had started the process of getting R2 out of bed with the Hoyer lift when her roommate required assistance. R2 was laying flat on her back with the Hoyer sling under her and from the other side of the room, approximately 30 seconds after leaving R2's bedside, he heard R2 screaming and she had fallen out of bed. CNA L reported it was later discovered someone had come in to clean the floors while R2 was out of her room, made the bed frame smaller (less wide) to fit out of the door and when it was placed back in R2's room it was not extended properly to support the mattress which led to R2 rolling out of bed. On 5/28/26 at 1:25 PM, during an interview with NHA (Nursing Home Administrator), when asked what she could tell me about R2's January 2026 fall, she reported it was witnessed, she was sent to the emergency room because she was having pain, they did a head CT (cat scan) and x-rays were negative. NHA further reported, upon investigation of the root cause it was determined a housekeeper had closed her bed (reduced the width) to take it out of the room and when it was brought back into the room it wasn't expanded properly and the mattress extended past the frame. The NHA reported, following the fall, they completed a facility wide audit of all beds to ensure proper fitting of the mattress and frame. NHA was unable to produce that audit prior to survey exit. The NHA was asked if she could provide the care plan update made to R2's care plan following the fall, and the NHA did not provide that information prior to survey exit. A review of the facilities policy titled Fall Management updated 7/8/25, documented in part The facility will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform catheter care consistent with professional standards for one Resident (#10) of three residents reviewed. Findings include:Resident #10 (R10)On 5/21/26 at 12:25 PM, R10 was observed sitting up in his wheelchair. R10 confirmed he had a suprapubic catheter. R10 reported it had recently gotten clogged and there were orders in place to keep it open (by flushing it regularly) but it has not been done.A review of the clinical record revealed R10 was admitted into the facility on 2/3/19 with diagnoses that included: chronic kidney disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R10 scored 14/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).A review of a Urology Office Visit note, dated 4/21/26, documented in part .presents today at the outpatient Urology office regarding urinary retention.He resides at a nursing facility and the catheter has been previously ordered to be changed every 4 weeks, however patient thinks it is longer between exchanges than that.Today he reports that the catheter seems to not work as well lately. He is noticing more leaking in his brief from the urethra and less urine in the bag. Him and the aide that is with him confirm he is NOT getting any catheter flushes. He is unsure but believes the catheter was last exchanged around 3 weeks ago.Catheter bag leaking, very minimal concentrated urine in bag. Brief is wet from leaking through urethra.Assessment/Plan: Resides at a nursing care facility, previously ordered to have catheter exchanged monthly however unsure if this is happening every month. Patient thinks it is longer between exchanges than that. He is not having any catheter irrigation/flushes. Today pt reports increased leaking of urine from urethra into brief. Feels the catheter is not working well.Discussed need for daily irrigation of catheter to prevent sediment build up which is likely what is causing the leaking through his urethra.We exchanged his 20 fr (French-unit of measurement) SPT (suprapubic tube-tube that is surgically placed directly into the urinary bladder) today in the clinic.Order placed for nursing to irrigate SPT daily with 50 ml normal saline and as needed for clogging of catheter.A review of R10's Medication Administration Record for April and May, revealed that staff were documenting completion of a twice daily 60ml flush, however R10 is alert and oriented with a BIMS of 14, reported that it was not being done and was seen by urology and their notes supported R10's claim.On 5/28/26 at 11:51 AM, during an interview with DON (director of nursing) when asked what the expectation was for flushing a suprapubic catheter, she stated that the most recent guidance was that a suprapubic catheter should be done as needed.According to the Cleveland Clinic Website (https://my.clevelandclinic.org/health/treatments/25028-suprapubic-catheter) It's important to rinse (flush) a suprapubic catheter with sterile water to help prevent blood clots from blocking the device and otherwise keep the catheter clean and working properly. You should flush your suprapubic catheter at least once a day.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately document wound care for one Resident (#13) of three residents reviewed. Findings include:On 05/21/2026 at 11:51 AM, during an interview with R13, he reported he had a current wound to his left foot. R13 stated the dressing is ordered to be changed every day and was not being completed, but instead it was being done when they get around to it, which he reported was about every 2 days.A review of the clinical record revealed R13 was admitted into the facility on [DATE] with diagnoses that included: Type 2 Diabetes, peripheral vascular disease and acute osteomyelitis, right ankle and foot. According to the Minimum Data Set (MDS) assessment dated [DATE], R13 scored 12/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition).On 5/27/26 at 1:32 PM, an observation of R13's wound dressing was completed with RN K. Dressing was observed to be clean, dry and intact (covered with rolled gauze). No date was observed on the dressing. RN K reported she would typically date each dressing and that she had completed it that same day.A review of R13's progress notes revealed the following notes from Wound Nurse Practitioner (Wound NP) S:5/21/26 .No blue foam noted on initial assessment.Plan: Chart reviewed. Patient evaluated. Blue foam over wound bed. Cover with bordered dressing.Staff stated that there were no blue foam available-patient gets supplies from (vendor name redacted). Bag of supplies including blue foam and cover dressing noted on patients night stand.4/30/26 He reports that outer dressing was changed yesterday but has not been changed since last week with provider visit.Dressing in place very saturated with dried drainage. Outer dressing changed yesterday per patient.Dressings must be changed regularly. Readdressed with nursing.4/23/26 Dressings must be changed regularly. Address with nursing.4/16/26 Dressing dated 4/9/26.Dressings must be changed regularly. Address with nursing.3/26/26 He is unsure if wound care had been performed in the past week.Discussed care with unit manager/nursing. I will have nursing leadership review importance of adhering to wound care orders. Dressing has not been changed in one week.A review of R13's Medication Administration Records revealed the following:May 2026, despite documentation from Wound NP S, indicating there wasn't any Blue Foam on residents wound on 5/21/26 and staff had reported Blue Foam was not available, the Blue Foam dressing was documented as being applied daily for the week of 5/15/26-5/21/26.April 2026, despite documentation from Wound NP S indicating wound care had not been completed for the week of 4/9/26-4/16/26, it was documented as being completed every day on 4/10/26-4/16/26 (for a once daily order that started on 4/10/26).Despite documentation from Wound NP S indicating wound care had not been completed for the week of 4/23/26-4/30/36, it was documented as completed every day on 4/23/26-4/30/26 (for a once daily order).March 2026, despite documentation from Wound NP S indicating wound care had not been completed for the week of 3/19/26-3/26/26, it was documented as being completed on 3/21/26 and 3/24/26 (for a 3 times per week physician order).On 5/28/26 at 10:01 AM, during an interview with Wound NP S it was reported he is from an outside service that rounds in the facility once per week on residents identified by the facility as needing wound care. Wound NP S reported he rounds with Nursing Administration P. When asked if there are any concerns with in house wound care, Wound NP S reported there are times when wound care had not been performed or not performed as per the order. When asked if he had observed wound care dressings that weren't dated and stated, on occasion, and his concern was when he would observe a date on the dressing and it wasn't the date that he expected it to be (indicating the dressing had not been changed as often as ordered). When asked about R13, Wound NP S reported he had been treating a wound to his left heel for a couple of months and healing is going slow. When asked if there are any concerns with wound care being performed in house, Wound NP S reported there had been a few times when wound care had not been done and the resident is able to report when it's completed and when (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235016	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Jackson	434 W North Street Jackson, MI 49202

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it is not. Wound NP S reported, his documentation in the electronic medical record reflected his observations of wound care not being completed by in house staff and sometimes the dressing he observes is the same dressing he had applied the week prior (indicating it had not been changed by floor staff for an entire week). Wound NP S reported he will typically report this to whoever he is rounding with, which is typically Nursing Administration P. Wound NP S further reported staff had mentioned running out of dressings, specifically blue foam. On 5/28/26 at 12:54 PM, during an interview with Nursing Administration P, it was confirmed she rounds weekly with Wound NP S, she takes the photos and Wound NP S performs the assessments. When asked if any audits are done to confirm completion of daily wound care, Nursing Administration P reported none were completed outside of the weekly rounds she completes with the Wound NP and no ongoing or widespread education on wound care had been done upon being notified of wound care not being completed for an entire week. When asked what the expectation is for dating the wound care dressings, Nursing Administration P reported she would like to see the date, time and nurses initials. When asked what she was aware of regarding wound care not being completed, she reported, once or twice in the past Wound NP S had reported wound care not being completed and one on one education was done with the nurse identified as not completing it. When asked about the facility not having necessary wound care supplies, Nursing Administration P reported she felt the issue was the treatment cart needed to be organized. When asked specifically about the blue foam, she reported, it's at the bottom of the cart and the staff don't really dig for it.