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	06/05/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, interviews and record reviews, the facility failed to maintain a clean, homelike environment 1) drywall cut away from the wall 2) vents covered with dust on the inside and outside, 3) toilet riser covered in feces that could potentially affect all residents.This citation pertains to intake # 3025074Findings Include: During observations on 06/02/2026 at 12:25 PM, several residents' rooms and bathrooms were not clean, open holes in the wall and not a homelike environment: Bathroom between rooms [ROOM NUMBERS], the vent in the bathroom was covered with dust in the vent and up inside the vent. Bathroom between rooms [ROOM NUMBERS] wall/drywall was cut out above the sink and under the sink due to a leak a month ago or more and was not repaired. Bathroom between rooms [ROOM NUMBERS], the vent in the bathroom was covered with dust on the vent and up inside the vent. Bathroom between rooms [ROOM NUMBERS], the vent in the bathroom was covered with dust on the vent and up inside the vent. Bathroom between rooms [ROOM NUMBERS], the vent in the bathroom was covered with dust on the vent and up inside the vent. Bathroom between rooms [ROOM NUMBERS], the vent in the bathroom was covered with dust on the vent and up inside the vent. Bathroom between rooms [ROOM NUMBERS], the vent in the bathroom was covered with dust on the vent and up inside the vent. During observations on 06/03/2026 at 10:16 AM, the bathroom between rooms [ROOM NUMBERS] were not clean, open holes in the wall and not a homelike environment. Bathroom between rooms [ROOM NUMBERS] had drywall missing from the ceiling, above the sink and under the sink. The floor in room [ROOM NUMBER] was sticky from something being spilt on the floor and not cleaned up, writer's shoes stuck to the floor. During observation and interview on 06/04/2026 at 2:26 PM, Maintenance Director I walked through the resident's rooms and bathrooms on 200 hallway and observed the missing drywall, open holes in (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the wall, exposed pipes with no cover over it to protect residents. Maintenance Director I stated it had to be fixed after a leak and added he doesn't have the material to fix it. Maintenance Director I stated it's been that way a couple of weeks. Writer asked what the plans were for repair. Maintenance Director I stated he had a contractor lined up and he didn't show up. Writer asked if he had a cleaning schedule when he made rounds and did deep cleaning. Maintenance Director I stated no he did not, he just cleaned when he got time to do it. Maintenance Director I stated he did not have a schedule to inspect, clean or log certain areas of the building in use and not in use, and added if it broke, he fixed it. Writer asked Maintenance Director I about the schedules for routine testing the water temperature and legionnaires testing. Maintenance Director I stated he checked it weekly. Writer asked to see his maintenance log, and the Maintenance Director I stated he doesn't have any logs. Maintenance Director I had been there 3 months, stating nobody was training him. Writer asked how he was keeping track of the of the water testing, legionnaire's testing, work orders, mechanical devices, call lights and other devices that affect the care and safety of the residents that needed checked, Maintenance Director I stated he did it when he could find time. Maintenance Director I had no documentation proving what he had done or not completed. During an interview on 06/05/2026 at 1:19 PM, Housekeeping Manager P stated he gave NHA A past cleaning logs to upload into Egress. Housekeeping Manager P explained the terminal cleaning instructions when a resident is discharged , or if they were in isolation and the in-depth cleaning that takes place. Housekeeping Manager P stated his staff do daily cleaning as assigned, showing writer a copy of the assignments and who had completed which rooms. Housekeeping Manager P observed the vents of concern and stated they were cleaned a week again but would make sure it was cleaned right away today. Housekeeping Manager P stated housekeeping cleans the outside and surrounding the vent, but it was Maintenance Director I responsibility to get up inside of the vents to clean them out. Housekeeping Manager P stated he didn't have his staff go up into the vents to clean. Writer reviewed cleaning logs provided by Housekeeping Manager P. On 6/3/26 at 9:13 AM, the shared bathroom between rooms [ROOM NUMBERS] was observed to have a urinal laying on it's side on the back of the toilet with a small amount of urine spilled on the top of the toilet, stool was observed both on the rim of the inside of the toilet and heavily soiled on the back of the toilet riser, additionally there was a soiled towel observed on the bathroom floor (soiled with a brown substance, consistent with the color of the stool observed on the toilet).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3031215 Based on observation, interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for one (R39) of two residents reviewed. Findings include:On 6/2/26 AM R39 was observed lying in bed. R39 reported that his only concern was that his bathroom was not being cleaned properly and that he had been asked by housekeeping to clean his own bathroom. R39 reported that the housekeeper asked him if he had asked the CNA to clean his bathroom, indicating it was the CNA's job to clean up stool. R39 reported that the housekeeper left a washcloth at his bedside and staff were told to not clean his bathroom until the resident had cleaned up his own stool. R39 indicated that Unit Manager (UM M) was made aware. R39 further reported that he had chronic diarrhea and used the toilet a lot and verbalized being upset by the staff member telling him to clean his bathroom. Review of the clinical record revealed R39 was admitted into the facility on [DATE] with diagnoses that included: dementia and depression. According to the Minimum Data Set (MDS) assessment dated [DATE], R39 scored 12/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition).Review of the Facility Reported Incident Summary revealed that R39 reported that housekeeper O told him he needed to clean the toilet after experiencing diarrhea, stating that the resident should clean it rather than staff.an investigation was completed, including interviews with the resident, assigned CNA (certified nursing assistant) , second CNA witness (CNA L) and the housekeeper involved. The resident stated that the housekeeper appeared upset about having to clean the toilet and indicated that he should clean it himself. The assigned CNA reported that she then handed the wipes to the resident. The housekeeper denied handing the wipes to the resident and stated that the CNA gave the wipes to the resident; however, he acknowledged that the wipes were intended for the resident. A second CNA, who was assisting another resident in a nearby room, stated that she heard the resident yelling and went to see what was happening. She stated she did not witness the direct interaction between the resident, assigned CNA and housekeeper, but her statement supports the resident's report regarding the concern raised at the time of the incident. Based on interviews conducted, the resident and assigned CNA provided consistent statements that the housekeeper indicated the resident should clean the toilet. While accounts differed regarding who physically handed the wipes to the resident, statements were consistent that the wipes were intended for the resident to clean the bathroom. This interaction is not consistent with the facility's expectations regarding resident dignity, respect and appropriate staff conduct. Following completion of the investigation and review of all statements obtained, the housekeeper's employment was terminated. The resident was interviewed regarding safety and voiced no further concerns at the conclusion of the investigation. No further related concerns have been reported.A 5/22/26 Statement from Housekeeper O, At approximately 10:00 am on 5/21/26 I was asked for the bleach wipes from (CNA N) and (CNA L) I observed the CNA putting the wipes on the bedside table and (CNA N) said you need to clean it up. The resident threw the wipes at the CNA and called her a b*tch. The CNA left the room and reported to the unit manager, and she went in to talk to the resident. She told the resident that it was housekeeping's job to clean it. On 5/22/26 I noticed there was a mess in the bathroom and I asked him if he let the CNA know and he started yelling at me. I cleaned it up. He got up and started yelling in the hall; he was getting in my face and told me I am forbidden to go into his room. I told him I wasn't arguing with him. I left the area.A 5/27/26 Statement from CNA L, I was in taking care of the next room and I walked out and heard (R39) yell Hey CNA, I don't have to clean the bathroom that is housekeeping's job. I did not witness any interaction between him or the housekeeper. Did you hand him wipes and tell him to clean the bathroom- No'A 5/26/26 Statement from CNA N, Sometimes (R39) will have diarrhea and will get it on the floor and toilet seat. (Housekeeper O) will have a fit if he has to clean it up. (R39) cannot (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	help it. I explained to (Housekeeper O) that if it is on the floor or the wall, I clean it up and if it is in the toilet then he needs to clean it up. He came to me in the hall and handed me Clorox wipes, and I thought it was for me to clean up, and stated just leave them there. He pulled a few out and left it on the table for the resident. As I turned around, (R39) yelled, I am not going to clean the toilet, it is housekeeping's job. He called me a b*tch and I left the room after I removed the Clorox wipes.A 5/22/26 Statement from Unit Manager (UM M), (name redacted-Housekeeper O) stated that (R39) is purposefully pooping every night. (R39) is offended by (Housekeeper O) because of the incident yesterday. Yesterday (Housekeeper O) was upset because the CNA would not clean the inside of the toilet bowl and felt the CNA should have cleaned it. Today (5/22/26) I was told by (name redacted) that the same incident occurred today. He stated that (Housekeeper O) went into the room and stated in a confrontational manner: Did you tell the CNA to clean it up? Referring to the issue of the toilet. During this conversation, he was on the phone with his girlfriend. As a follow up, I spoke with (R39) regarding loose stools. He stated that at home he took metformin and his PCP (primary care provider) took him off metformin due to uncontrollable diarrhea. I spoke with the NP (Nurse practitioner) about changing his medication since he had diarrhea. His medication order was obtained and ordered.Review of R39's progress notes revealed the following:5/18/26 Resident was seen by facilities Nurse Practitioner related to flatus (gas) at the request of nursing staff, Was asked to see this (age redacted) year old male by nursing staff's concern of increased flatulence and frequent bowel movements.Patient stated the is eating and drinking well, denies any nausea or vomiting. Patient states he is having 1-2 bowel movements a day. He does endorse passing gas, does not cause any discomfort.Patient having regular bowel movements.Is having regular bowel movements 1-2 a day, denies any diarrhea.5/21/26 Resident was seen by UM M, Referring to BCS (Behavioral Care Solutions-mental health services provider) for behaviors. Resident continues to purposefully defecate on a shared bathroom floor and all over the toilet. This occurs multiple times a week. Resident will not engage in conversation about this behavior.5/22/26 Resident was seen by facilities NP related to diarrhea, The patient was asked to be seen today due to continued diarrhea, patients feels that his diarrhea is related to medication. He would like to be off metformin, upon review of medication patient is not on metformin. Discussed with patient, we will monitor blood sugars and diarrhea.Intermittent diarrhea, will continue to monitor, patient is not on metformin, will hold Metamucil as fiber could be causing some increased indigestion.5/22/26 Resident was seen by UM M, UM discussed behavior with resident and reviewed his medications with him. Resident said that he used to take metformin at home for his DM (diabetes mellitus) but it gave him uncontrollable explosive diarrhea so Dr put him on Jardiance. Resident stated that he does not have any GI (gastrointestinal) issues when taking Jardiance. UM asked Dr to discontinue metformin and order Jardiance.Review of the facilities policy titled Abuse Prohibition Policy updated 9/9/22, documented in part Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property.To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents.Definitions.Verbal abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the guest/resident to experience humiliation, intimidation, fear, shame, agitation, or degradation regardless of their age, ability to comprehend or disability. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to guests/residents within hearing distance, regardless of age, ability to comprehend, or disability.

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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 #3027512Based on observation, interview and record review the facility failed to thoroughly investigate an allegation of drug diversion for one resident (R14) of two residents reviewed.Findings include:A review of the clinical record revealed R14 was admitted into the facility on 3/30/23 with diagnoses that included: bipolar disorder and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R14 scored 7/15 on the Brief Interview for Mental Status exam (which indicated severely impaired cognition).On 6/2/26 at 3:57 PM R14 was observed self-propelling a manual wheelchair in the hallway and resident was heard asking what he is supposed to be doing and stating he didn't know what was going on, without being prompted.A review of FRI (Facility Reported Incident) 5-day summary, completed on 5/24/26 revealed On 5/19/26 nurse (LPN Y) was suspended pending investigation following reasonable suspicion of possible medication diversion related to review of PRN (as needed) narcotic administration for a resident (R14) under her care. (LPN Y) was the only person identified as signing out the PRN narcotic in question during the timeframe reviewed.The facility initiated an immediate investigation. Medication Administration Records (MAR), electronic health record documentation were reviewed to verify timing, dosage, route and documentation of medications administered. Review identified documentation discrepancies between the MAR and narcotic sign-out sheets related to recording practices; however, no discrepancies were identified indicating medication was missing, diverted, withheld, or administered inappropriately.Relevant staff members involved in medication administration and medication counts were interviewed. Staff reported no concerns regarding the nurse's medication administration practices and denied observing missed, altered, delayed, or otherwise inappropriate medication administration. Interview findings were consistent with documentation reviewed. The 10-panel drug screen results returned negative for narcotic use. Conclusion: Based on review of medication records, narcotic documentation, resident interviews, staff interviews, and negative drug screen results, the facility found no substantiated evidence of medication diversion or medication administration misconduct involving nurse (LPN Y). While documentation variances between the MAR and narcotic sheets were noted, there was no evidence that medications were diverted, withheld, or administered outside physician order parameters. Investigation findings support that medications were administered as ordered and residents received prescribed medications without adverse outcome. Investigation is closed as unsubstantiated. LPN Y was re-instated on 5/22/26.Included in the FRI investigation folder were the following statements:5/19/26 LPN D, On 5/19/26 I asked the doctor if Norco for (R14) could be discontinued as I noticed only one person was signing it out and it started in January. I suspected abuse. (Physician's name redacted) said he would tell Admin and DON.5/28/26 UM M, I review the narcotic cards and have not seen a pattern of diversion. I have not seen any factual evidence to support drug diversion. Narcs in the carts are counted at shift change as they should be.A review of R14's Norco Controlled Drug Receipt/Record/Disposition Form (paper record used to account for narcotic medications being signed out) with date span of 9/30/25-5/9/26 revealed that 28 doses were given during that time, the last 15 were signed out by LPN Y (date span of 4/5/26-5/9/26) and that the last time R14 had been given a dose by anyone else was almost 3 months prior on 1/9/26. A second Controlled Drug Receipt/Record/Disposition Form with a date span of 5/12/26-5/19/26, was reviewed and revealed all 5 doses were signed out by LPN Y, therefore the last 20 doses that were documented as being given to R14 were signed out by LPN Y exclusively.A review of R14's pain scores for the timespan in question revealed that LPN Y did not consistently record pre and post administration pain scores as per standard of practice.On 6/4/26 at 10:01 AM during an interview with LPN D it was reported that R14 had been getting Norco for reported pain dating back to November 2025 but that all staff, except LPN Y had stopped giving it to him because he had an adverse reaction (nausea and vomiting). LPN D reported that R14 refuses his medications (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	often, so it seemed unusual that LPN Y kept documenting that she was giving R14 the Norco each night she was working. LPN D reported that after the suspicion of drug diversion was reported a urine drug test was completed on R14 which was negative for opiates. LPN D reported that leadership (DON/NHA and ADON) were made aware and she was told that it would be taken care of. LPN D reported that NHA A had just taken her statement on Monday (6/1/26) when the incident had been reported on 5/19/26. It should be noted that LPN Ds statement provided in the FRI folder had a date of 5/19/26. LPN D further reported that the facility physician had ordered a blood drug screen to be ran with blood that was collected and sent to the laboratory however it was never resulted (no physician order for a blood drug screen was found in R14's record). On 6/4/26 at 10:40 AM during an interview with NHA A and DON B, DON B reported that it was brought to their attention by the facilities physician, during their morning meeting, that LPN D had expressed concern regarding drug diversion and that LPN Y was the only nurse signing out R14's Norco. DON B stated that she went through all the narcotic sign out sheets for all residents that had narcotics, looked for a pattern of abuse, and then looked into the electronic medical record to verify the medications were documented appropriately. DON B reported that she did not notice any patterns of diversion. When asked to explain what a pattern of diversion might look like she explained it would depend on the medication but if the medication was missing/not documented on the Medication Administration Record. I verified that DON A was aware of the last several doses being signed out solely by LPN Y, she was aware. When asked what was meant by documentation variances mentioned in the FRI investigation summary, DON B reported that there was a discrepancy between the times when the Norco was signed out on the narcotic sheet and when the medication was documented as being given on the MAR. DON B reported that this was not best practice but not diversion. DON B reported that LPN Y had a negative drug test and by the time the results had been returned she had reviewed a lot of charts and spent a lot of time ruling out drug diversion, so LPN Y was allowed to return to work.On 6/4/26 at 3:29 PM, during a telephone interview with LPN Y, it was reported that she was suspended pending an investigation of suspected drug diversion. She provided an observed urine sample for a drug test that was negative. LPN Y originally stated that she was not aware of the allegation being about a specific resident then recalled someone on the floor asking her about providing R14 with Norco, which she reported she gave him for his agitation and dementia. LPN Y denied any drug diversion and stated that she followed the physician's order. LPN Y reported that R14 appeared uncomfortable, had pain in his legs/back/hips and prior to her giving him the Norco would be wanting to punch staff. LPN Y reported that the Norco helped with some of R14's behaviors. LPN Y reported that a pain score should be recorded prior to giving a pain medication and again an hour or 2 after to determine if it was effective. When asked about pain scores not being recorded consistently she reported that she was surprised. When asked why it had been reported that R14 had a negative urine drug screen for opiates she reported not knowing why. LPN Y was asked about the more recent incident involving a Norco being taped back into the narcotic card, she reported that she did not know how it had happened but that it was reported to UM M. When asked if that incident had been investigated she replied, I don't think so, it happened recently, that she was not asked for a statement and had not heard anything more about it.Review of progress notes written by LPN Y (from 4/5/2026 to current) revealed the following:4/5/26 2:24 AM (R14-name redacted) continually refuses his evening medications. Despite the risks of refusing medications and he said I don't care. Doctor will be notified via doctors book. POA (power of attorney) will be notified in day time.4/5/26 11 PM (R14-name redacted) spent the evening propelling himself around the third floor. He is friends with other residents who sit with him during meals and when doing activities. He finally took his medications for me. His friends encourage him to take his medications and (R14-name redacted) does it. He did very well this evening and I was able to address his pain issues. He slept most of the night. He said he enjoyed talking to me so I am hoping as he will remember me enough to take his medications in the future and not refused his medications which had become his norm.4/29/26 6:55 AM (R14-name redacted) looks like he doesn't (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feel well. He looks weak and wants to be left alone. His color is pale. He doesn't want to get OOB (out of bed). His urine is foul smelling. He is more aggressive then he has been this is from day CENA reports. Will leave note with doctor. Will talk to day nurse.There was only one mention of R14 being aggressive and no documentation to support LPN Ys report of his pain or him wanting to hit staff.On 6/4/26 at 4:10 PM during an interview with UM M, when asked about the suspected drug diversion involving LPN Y, she reported that she had been asked to pull the narcotic logs which she provided to the DON and NHA. She further reported that she had no proof diversion occurred. When asked about the incident that occurred over the weekend, involving the wrong pill being taped into a narcotic card she reported that she was made aware because she was on-call, a nurse identified that there was a card for a resident that was no longer in the facility, and a different tablet had been taped into the card. The card was for Norco 7.5mg and the one taped in was Norco 5mg. When asked what had been done about this, she reported that she had the nurse write a statement, take photos of the pill card and lock it in a different medication cart. When asked what she thought had happened she reported that it was quite obvious that someone had swapped the pills. When asked if there was a concern for drug diversion UM M reported that her initial reaction based on the other recent allegation against LPN Y was yes there was a concern for drug diversion. When asked if she knew who could have taped the pill back into the narcotic card, UM M reported that she saw LPN Ys initials on the narcotic sheet and she is familiar with her signature. When asked if potential drug diversion should be reported to the State, UM M reported yes if it was diversion and that she was not aware of the timeline for reporting to the state or the process for reporting to the State. When asked if it should have been reported to the NHA (nursing home administrator) at the time of discovery she reported looking back I guess I probably could have.On 6/5/26 at 8:59 AM, during a follow up interview with NHA A and Director of Nursing (DON) B, I asked DON B to confirm that when she reviewed the Medication Administration Records and compared them to the Narcotic Count Sheets that the only discrepancy was related to the times being off, DON B confirmed that was correct. I reviewed the 2 narcotic sheets for R14's Norco with NHA A and DON B and 4 of the doses signed out by LPN Y were not documented as being given on R14's MAR. DON B replied I don't know how I missed this, it's a lot. When asked if a urine drug test had been done on R14, DON B reported an unofficial one had been done, it was collected in house but then she was told that the in house tests could only be used for new hires and that the test was never resulted, and that their contracted lab could not do urine drug screens or blood. When asked about the more recent incident both NHA A and DON B initially reported not being aware of an incident related to narcotics over the weekend. DON B clarified that she wasn't sure what day it had occurred, but it happened over the weekend and that she was just going by one of the nurse's statements. When asked for additional details regarding that statement, DON B reported that LPN Q had reported that there was a different imprint on one of the pills in a Norco card. DON B reported that she spoke with LPN Y that day and that her and NHA A had talked about reporting that morning (it should be noted that the day of the interview was Friday-almost a full week after the incident occurred). When asked when she was made aware, DON B reported it had been a few days since a letter was dropped under her door. When asked if the police were called for either incident, NHA A reported they were notified of the first incident but not the most recent one. NHA A provided a business card from a local police department, that she had in a separate/personal notebook. The facility FRI investigation provided by the facility for review for the 5/19/26 allegation of drug diversion did not include a police report and the facilities investigation summary did not mention notification of the police, it did not include MAR's that were reviewed for administration of the Norco in question, and it did not include copies of the narcotic logs that were reviewed for the Norco in question. The separate and second incident that occurred on 5/30/26 had not been formally investigated.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 3030189. Based on interview and record review, the facility failed to provide a written notice of transfer for one (R75) of two reviewed. Findings include: Review of the medical record revealed R75 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/8/26 revealed R75 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R75 transferred to the hospital on 5/17/26 and did not return to the facility. Review of the Nurses Notes dated 5/17/26 revealed R75 was transferred to the hospital. The notes revealed the ambulance was given paperwork that included R75's admission Profile, Order Summary, and Code Status. The bed hold policy was explained to the family. Review of the eInteract Transfer Form revealed R75 was transferred to the hospital on 5/17/26 at 6:15 PM for shortness of breath. In an interview on 06/05/2026 at 1:20 PM, Director of Nursing (DON) B reported the bed hold policy was given to the resident upon transfer to the hospital. When asked about a written notice of transfer, DON B reported the only transfer form she was aware of was the eInteract Transfer Form which was given to the ambulance staff and not the resident. The DON B agreed the eInteract Transfer Form did not include information regarding appeal rights and the contact information for the State Long Term Care Ombudsman. On 06/05/2026 at 3:27 PM, DON B reported the facility had a written transfer form they were supposed to use, but it was not given to R75.

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	235016	A. Building B. Wing	06/05/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to provide accurate Minimal Data Set (MDS) assessments for one resident (R20) of 15 residents reviewed for accuracy of assessments.Findings include;Resident #20 (R20)Review of the medical record reflected R20 was an initial admission to the facility on [DATE]. Diagnoses of rheumatoid arthritis, multiple sclerosis, polyneuropathy, osteoarthritis, spinal stenosis lumbar region, functional quadriplegia, anxiety and depression.The most recent Minimum Data Set (MDS) with an ARD/Target date of 03/26/2026 revealed R20 had a Brief Interview of Mental Status (BIMS) of 13 (cognitively intact) out of 15. Under section GG0115, Functional Limitation in Range of Motion revealed R20was independent with eating and use of upper extremities. Under section GG0130, Self- Care, R20 was dependent on care for toileting, hygiene, Shower/baths and transfers.Record review of Minimum Data Set (MDS) revealed R20 was on an antibiotic, through further investigation, this resident was not on an antibiotic during time frame of 03/26/2026.On 06/03/2026 at 10:44 AM, writer emailed LNHA A requested R20's March and April's Medication Administration Record (MAR) and any orders for an antibiotic as documented on the MDS quarterly assessment. On 06/03/2026 at 11:25 AM, LNHA A forwarded email from DON A stated, I have reviewed R20's chart, and she was not on an antibiotic, no orders for an antibiotic for this resident.During an interview on 06/03/2026 at 2:05 PM, DON B stated she wondered why writer asked her to look at this, as R20 had not been on an antibiotic so it must have been an MDS discrepancy.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to administer medications timely and document accurately for one resident (R32) of 15 residents reviewed.Findings Include;Resident #32 (R32)Review of the medical record reflected R32 was an initial admission to the facility on [DATE]. Diagnoses of osteoarthritis in the right knee, acute embolism and thrombosis of the right knee, obesity, diabetes mellitus 2, obstructive sleep apnea, pain in left hip, major depression and anxiety.The most recent Minimum Data Set (MDS) revealed R32 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0115, Functional Limitation in Range of Motion revealed R32 was independent with oral care and eating. R32 was dependent on care for toileting, hygiene, Shower/baths and transfers.During an observation on 06/02/2026 at 4:39 PM, writer standing outside the room of R32 and over-heard R32 ask Licensed Practical Nurse (LPN) Q for her Nicotine Lozenges and LPN Q told R32 she already had it but R32 stated she has not.During an interview on 06/02/2026 at 4:40 PM, writer asked LPN Q if R32 could get her Nicotine Lozenges, writer had already run the Medication Administration Record (MAR) and R32 did not have any medications signed out today. LPN Q stated she had already given it to R32, writer told her there was not any Nicotine Lozenges signed out today. LPN Q stated she didn't always sign her medications out if she is busy. Writer asked LPN Q when R32 received Nicotine Lozenges, LPN Q stated that morning and about 15 minutes ago. Writer asked for times that Nicotine Lozenges were administered and LPN Q stated somewhere around 8:30am and about 15 mins ago. Writer informed LPN Q that Nicotine Lozenges had not been charted for today. During an interview on 06/02/2026 at 4:45 PM, writer asked DON B to print the medication administration record of actual time LPN Q signed out Nicotine Lozenges for R32, LHNA A was present in DON B s office during this interview. Writer added there was a concern with R32 was not getting her Nicotine Lozenges twice today, LPN Q stated she gave it, R32 stated she never received it, nor was it signed out as given. DON B pulled up the report and verified that LPN Q signed out both Nicotine Lozenges given at 16:46 PM, not at 08:30 AM nor at 16:15 PM when LPN Q stated she gave them. Writer reported there was a problem with R32 reported not receiving her Nicotine Lozenges as ordered. Writer requested a copy of the MAR report, uploaded to Egress.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide medically related social services for one resident (R65) of one resident reviewed for services not received.Findings Include;Resident #65 (65)During an interview on 06/02/2026 at 1:06 PM, R65 stated she doesn't have her power wheelchair back yet. R65 stated again if I had my mother fucking chair fixed, I wouldn't have to be stuck in this damn bed all day! Writer asked R65 how long she had been without her powered wheelchair and R65 stated months, last fall sometime.On 06/03/26 at 3:00 PM, writer emailed Guardian Z related to the repair of her powered wheelchair, Guardian Z emailed back. Guardian Z stated no, she still had not heard anything back from repair company but was going to call them again.On 06/03/26 at 3:30pm- writer requested the repair company's name and phone number, Guardian Z stated yes, and shared the only number she knew of and it was their customer service, given phone number. Guardian Z stated she filled out the Contact Us form on their website and still hadn't received a response.During an interview on 06/04/26 at 4:40pm, writer placed a call to repair company at the given number. Writer spoke to a receptionist, stated she had to transfer writer to another department. Writer had to leave a voicemail, requesting a call back by tomorrow. During an interview on 06/05/2026 at 8:44 AM, writer called the repair company at the given number and received a message that they were not open at this time. Did not leave a message, will call back. During an interview on 06/05/2026 at 10:16 AM, Licensed Practical Nurse (LPN) D stated R65 had not had her power wheelchair since last fall. LPN D stated she was not sure what was wrong with it, but it isn't working. LPN D stated she talked with R65 that morning and R65 told her she wanted to get up out of her bed today, and LPN D stated she was going to make sure that happens. Writer asked LPN D how R65 would get around after she was transferred via mechanical lift into a manual wheelchair and was unable to get herself around with her paralysis. LPN D stated R65 would need someone to take her wherever she wanted to go. LPN D added activities were taking residents outside today and she would make sure R65 got outside today. Writer asked LPN D about changes in the care needs of R65 related being stuck in bed 24/7 and no way to get around. LPN D stated she was on the call light more for the little things she could not get herself, increased frustration because of being in her room [ROOM NUMBER]/7 and bored and was socially isolated. LPN D also stated R65 now had more issues with compromised skin integrity on her back side. LPN D stated the provider came in that week and looked at her altered skin integrity and told the resident she needed to get off her back side. LPN D stated she would get R65 up in the manual wheelchair and get her outside. During an interview on 06/05/2026 at 10:20 AM, R65 stated it was hard staying in this room [ROOM NUMBER] hours a day, 7 days a week. R65 stated she only had her TV and cell phone and stated she may have been on the call light more because she cannot get out of this room because nobody would see that her powered wheelchair got fixed. R65 stated this was not right, it was causing social isolation, decreased quality of life, and they didn't care. R65 stated they moved her powered wheelchair from the hallway out to the garage. R65 stated this was no way to live, in the same room [ROOM NUMBER]/7 with no means of getting around herself. R65 stated nobody had updated her on the progress of the repair of her power wheelchair. R65 stated it pissed her off, made her frustrated and mad, nobody cared that she couldn't get around, nobody cared that the powered wheelchair didn't work. R65 stated they would tell her they didn't have enough staff available to wheel her around. R65 stated she wasn't usually depressed, but this situation has really affected her mentally and emotionally. During an interview on 06/05/2026 at 10:54 AM, with repair company and spoke with receptionist who wanted to transfer this call to that department, writer explained that we have had several calls transferred to that department and no call back. Receptionist asked writer to hold on so he could see if there was a manager available. The Receptionist came back on the call and stated the supervisor would call writer back.During an interview on 06/05/2026 at 2:23 (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, DON B stated she was unsure what was wrong with the powered wheelchair and why it was not getting fixed. DON B stated that LHNA A said something about the family didn't want to pay to get it repaired.Received a call back from the repair company that went straight to voicemail stated they had been in contact with R65's sister who knew nothing about the powered wheelchair, and because she didn't know what was wrong, they couldn't schedule a repair visit.During an interview on 06/05/2026 at 2:53 PM, Guardian Z was updated that the repair company was contacting the sister who had nothing to do with making medical decisions. The repair company had not been updated with the Guardian Z contact information by the facility. Writer asked Guardian Z to provide the up dated information with her contact information so they can contact the correct person. Had the facility provided the updated Guardian information to the repair company, R65 may not have had to wait months to get her powered wheelchair repaired. R65 may not have had to spend months in her bed, in her room, 24 hours a day, 7 days a week.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Citation pertains to intake #3030189Based on observation and interview the facility failed to ensure medication administration was observed with a nurse for one resident (R3) of one resident reviewed.Findings include:Resident #3 (R3)Review of the medical record reflected R3 was an initial admission to the facility on [DATE]. Diagnoses of osteoarthritis in the right knee, acute embolism and thrombosis of the right knee, obesity, diabetes mellitus 2, obstructive sleep apnea, pain in left hip, major depression and anxiety.The most recent Minimum Data Set (MDS) revealed R3 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0115, Functional Limitation in Range of Motion revealed R3 was independent with oral care and eating. R3 was dependent on care for toileting, hygiene, Shower/baths and transfers.During an observation and interview on 06/03/2026 at 9:34 AM, writer observed several of R3's medications in the med cup that were left on her over the bed table. No nurse was present in the room to observe R3 taking them. R3 stated the nurses usually leave her medications on the bedside table for her to take. R3 stated she had to take some of her pills on a full stomach, and others needed to be after that. During an interview on 06/03/2026 at 12:58 PM, Licensed Practical Nurse (LPN) D stated R3 was particular on how she took her medications, she would not take them at once. LPN D stated she went in there and R3 wouldn't take her morning medications at that time. Writer asked LPN D if R3 had been evaluated for self-administration of her medications. LPN D stated R3 had not been evaluated for self-administration of her medication and stated R3 would tell nursing how she wanted to take her medications. During an interview on 06/03/2026 at 1:26 PM, writer asked DON B what her expectations were for administering medications to residents. DON B stated hand hygiene, right resident, right medication, right route, right time, right dose and document administration of medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews the facility failed to effectively 1) date all ready-to-eat food. 2) remove expired food. 3) effectively clean equipment potentially affecting all residents who resided in the facility and received food from the kitchen.Findings Include; During initial walk through on 06/02/2026 at 8:44 AM, it was noted that there were spices that were not dated when they were opened, no date when they expired. Chicken seasoning, black pepper, Dietary Manager V stated they came in on 05/24/26 so she wrote that date on the 2 containers, but no open date or expiration date. Observation of 6- 16oz bags of On-Top whipped topping with no receive dates or expirations dates. Angel food cake dated 05/01/26, unopened, expired 06/01/2026 and was not discarded. Observation of a large zip locked bag of Bacon- 5 pounds- dated 05/24/26, however the package was wide open, not sealed shut, and edges of the bacon were drying out.Dietary Manager V threw away the items of concern at the time of the observations. The Volcan double oven needed cleaning due to debris on the drip sheet/cookie sheet laying in the bottom of the top oven to catch grease and droppings. Dietary Manager V was asked how often they clean the kitchen equipment and kitchen overall, Dietary Manager V stated they try to do it weekly. Writer asked if they had a cleaning calendar written out on what equipment gets cleaned when? Dietary Manager V stated she saw an electronic calendar on her computer but couldn't pull it up, so she had to make a new one.Observation of the Dish machine low temp log was not checked on 06/01/26 for none of the 3 shifts. Was checked 1st shift on 06/02/2026.During an observation and interview on 06/03/2026 at 3:00 PM, writer noted the large six section steam table, with 6 shafting dishes/6 pans that sit down into the steaming table with covers. Observed edge of the steam table at the lip where the shafting rested on it, was dirty with buildup and stained. The bottom of the steam table had visible dark substance buildup, floating elements and stained. Dietary Manager V stated they change the water daily but didn't have a log or document to showing that changing the water or cleaning was being done. Santi-bucket sitting by the sink half full to use on the clean and dirty tables. Dietary Manager V stated they change it often, when it appears dirty. During an observation and interview at 4:30 PM, a repairman had been called to come and look at the stand-up steamer, as it was not functioning properly. The repair man stated the door gasket and screws needed replaced. He stated if the probe isn't sitting down in the water in the base of the steamer, it will not work. He stated he cleaned out the bottom of the steamer, as there was an oily mixture and the probes would not detect water to start heating. Stated he cleaned the unit and stated it is safe to use. Writer observed the repair man instructing Dietary Manager V on how to clean this equipment moving forward and how often it needed to be cleaned.