STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37872 This citation pertains to intake MI00146674 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #2) was free from abuse of three reviewed, resulting in Resident #2 being abused by a staff member. Findings include: Review of Abuse Prohibition Policy last revised 9/9/22 revealed Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposes of discipline or convenience that are not required to treat guest's/resident's medical symptoms. Further review of the policy reflects 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 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 . Resident#2 (R2) Review of a facility Admission Record reflected R2 readmitted to the facility on [DATE] with diagnoses that included severe intellectual disabilities, major depressive disorder, anxiety disorders, dysphagia oropharyngeal phase (difficulty swallowing), dementia, and late onset Alzheimer's Disease. Review of an annual Minimum Data Set (MDS) assessment dated [DATE] reflected R2 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14/15. Resident resides in the facility's Memory Care Unit. Review of the facility reported incident dated 08/23/2024 reflected Certified Nursing Aide in Training (CNAT) C observed R2 being physically and verbally abused on two occasions by Certified Nursing Assistant (CNA) B while providing care before and after dinner. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the facility reported incident documents reflected CNAT C reported allegations of abuse perpetrated by CNA B toward R2 to the Human Resources on 8/23/24. Review of the documents reflected CNAT C allegedly witnessed CNA B yelling and swearing at R2. CNAT C further alleged that CNA B placed the palm of her hand over R2's mouth. Review of CNAT C's interview by HR (Human Resources) (Name of HR H) and ADON (Assistant Director of Nursing) I on 08/23/24 reflected, that on 8/21/24 right before dinner she (CNAT C) was providing care to [Name of R2] in his room and needed additional help as he was not standing well. She asked [Name of CNA B] to assist her. [Name of CNA B] accompanied me to [Name of R2's] room and closed the door. While providing care [Name of R2] was yelling out and [Name of CNA B] said shut the f*ck up, I can't help you, if you keep yelling. We finished care and walked out of his room together. After dinner I went back to [Name of R2's] room where [Name of CNA B] was preparing to take his blood pressure. [Name of R2] was yelling and [Name of CNA B] said shut the f*ck up, don't yell at me like a retard, then she placed the palm of her hand over his mouth. [Name of R2] flailed his arms and hands up removing her hand from his mouth and [Name of CNA B] stated well than stop yelling. After this we left the room together. Review of CNA B's interview by ADON I on 8/23/24. CNA B initially stated that she did not call the resident a retard but that she stated to the resident You don't have to yell at me, you're not a retard, you can talk to me like a normal person. When asked if she covered his mouth she stated, I put my finger over his mouth and told him to sshhh. The NHA completed a follow up interview with CNA B on 8/27/24. CNA B stated that on 8/21/24 she was orientating a new employee. She entered into to R2's room to change him due to being incontinent. [Name of R2] was yelling so I raised my voice in attempt to get him to hear me over his yelling for him to calm down. I told him to stop yelling and stated that you're not a retard you don't have to yell. I tried several times to explain the cares I was going to provide however he kept cutting me off and continued to yell in my face, so I placed my finger over his mouth in attempts to get him to quiet down. [Name of R2] was flailing his arms and legs at this time and while doing so he used his arm/hand to move my fingers away from his mouth. We then finished his cares and left the room . [Name of CNA B] denied telling the resident to shut the f*ck up She admits to being frustrated with his yelling and behaviors and stated she was trying to get him to stop yelling. During an observation and interview on 9/3/24 at 11:10 AM, R2 was laying in bed awake and confused. R2 yelled and screamed when questions were asked and denied staff were mean to him. R2 cut off the interview by yelling GO. During an interview on 9/3/24 at 3:16 PM, CNAT C revealed that during care for R2, CNA B was swearing and name calling when she was doing his care. [Name of CNA B] was getting upset about his yelling and I saw her cover his mouth with her hand for a few seconds and stated, I can't take care of you when you're yelling at me like a retard. CNAT C further revealed that I was told the aide [Name of CNA B] would talk/swear like that when she was frustrated with residents and staff. CNAT C confirmed she was a new aide and stated, I was re-educated on reporting right away to my charge nurse any incidents of abuse and I had to sign a paper. Review of CNAT C's employee file reflected an Employee Education for Reporting abuse to the supervisor timely w/in (within) 2 hours of the incident occurring. Further review of the Employee Education reflected, CNAT C signed and dated the education on 8/23/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/24 at approximately 2:20 PM, the DON revealed that CNA B was not allowed to return to the facility. The DON provided a copy of Certified mail dated August 29, 2024, as a result of violation of HR Policy 311.00 Work Rules, #41 which states: 41) Employees may not physically, verbally, emotionally, or psychologically abuse a resident, visitor, or another employee or engage in a serious violation of a resident's rights or patient care standards. Review of the certified mail sent by [Name of HR H] reflected she (CNA C) was being separated from employment as of August 29, 2024. Further review of the Certified mail revealed, It was reported that you told a resident to Shut the f*ck up and placed the palm of your hand over the resident's mouth. As a result, this incident has been reported to the State Licensing Board per our legal requirement.