

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Regency at Fremont		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073</p> <p>Based on interview and record review, the facility failed to protect the resident's (Resident #2) right to be free from sexual abuse by a resident (Resident #1).</p> <p>Findings:</p> <p>Resident #1 (R1)</p> <p>Review of an Admission Record reflected R1 admitted to the facility with diagnoses that included dementia, mood disorder due to known physiological reason and a personal history of traumatic brain injury.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R1 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4/15. R1 exhibited A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching grabbing, abusing others sexually as well as wandering behaviors in 1-3 days during the look back period.</p> <p>Review of a mental health consult note dated 12/10/24 reflected R1 had sexually inappropriate behavior on 11/19/25 (it was alleged R1 touched a female resident's breast). The note indicated R1 started to masturbate in public on 11/21/24. On 11/23/24 R1 attempted to walk out of his room with his penis exposed. On 12/4/24, R1 became aggressive with staff who were attempting to redirect R1 away from another resident's room.</p> <p>Resident #2 (R2)</p> <p>Review of an Admission Record reflected R2 admitted to the facility with diagnoses that included dementia, schizophrenia, and anxiety.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a quarterly MDS assessment dated [DATE] reflected R2 was severely cognitively impaired as evidenced by a BIMS assessment score of 00/15. R2 exhibited D. Altered levels of consciousness - Did the resident have altered level of consciousness as indicated by any of the following criteria? -vigilant - startled easily to any sound or touch; - lethargic - repeatedly dozed off when being asked questions, but response to voice or touch; - stuporous - very difficult to arouse and keep aroused for the interview; - comatose - could not be aroused. The assessment indicated the behavior was continuously present, does not fluctuate.</p> <p>Review of a Facility Reported Incident (FRI) reported to the State Agency by the facility indicated that on 1/18/2025 at 9:11 PM it was discovered that there was a resident-to-resident sexual abuse incident. A statement provided by Certified Nurse Aide (CNA) B reflected the following: (CNA B) stated that she opened the door to (R2's) room and noticed that (R2) was lying bed naked on her right side facing the door. Her clothes were on the floor beside the bed and her brief was up by the head of the bed by the wall. (CNA B) is unable to recall where the blankets to (R2's) bed were at the time of the incident. She states (R2's) hands were crossed down in front of her body. She states that (R1) was standing at the head of the bed with his left side tight to the wall with his back to the wall with the door, his shirt was off and his pants were down around his ankles and both of his hands were on (R2's) head and he was pulling her head toward his body. (CNA B) stated that when she yelled get out (R1) replied 'why' and she stepped in between the two. She said that it all happened very quickly and that she isn't sure how or why (R1) fell but he fell on her his back to her front. She stated that when she entered the room and stepped between them (R2) looked at her with a blank look. When asked if (R2) was yelling or pushing him (R1) with her hands or any other type of defensive action (CNA B) stated no.</p> <p>Review of a Care Plan initiated on 10/16/23 and revised 8/26/24 reflected (R1) is experiencing episodes of hypersexuality. He tends to be sexually inappropriate towards staff, his lack of awareness/care for others being present, lack of awareness of others personal space and boundaries regarding personal spaces and masturbates compulsively in public areas or in view of others. He displays inappropriate sexual behaviors at inappropriate times. (R1) will exit his room with his pants down, exposed. Requires several reminders to pull up pants and cover self. An intervention on the care plan initiated on 11/20/24, resolved 1/27/24 (the intervention was active on 1/18/25) was (R1) needs to be in direct supervision of staff at all times when not in bed.</p> <p>Further review of the Care Plan reflected that on 11/29/23 is was identified (R1) has a (sic) actual behavior problem R/T (related to): entering other residents' rooms, turning lights on and off throughout the building, cleaning the bathrooms, etc. The goal of the care plan focus area was that R1 would be free of inappropriate behaviors through next review. Interventions included (R1) is on 15-minute checks r/t safety and behaviors.</p> <p>During an interview on 2/5/25 at 1:40 PM, CNA B reported she witnessed R1 and R2 on 1/18/25 as described in the FRI. CNA B said she knew R1 was on 15-minute checks and needed to be directly supervised by staff when out of bed. CNA B said she had been assisting another resident at the time of the incident and did not know who was responsible for directly supervising R1. CNA B had last seen R1 near the nurse desk.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/5/25 at 2:15 PM, Licensed Practical Nurse (LPN) A reported she was on the unit but was not supervising R1 at the time of the incident on 1/18/25. LPN A said she knew R1 was to be directly supervised by staff when out of bed and was also on 15-minute checks. LPN A did not know where or when R1 was last seen by staff.</p> <p>During an interview on 2/5/25 at 2:40 PM, CNA L reported they were in another resident's room at the time of the incident between R1 and R2 on 1/18/25. CNA L knew that R1 was on 15-minute checks and was to be directly supervised by staff when out of bed. CNA L was not sure where R1 was last observed and said It sucks, it (the resident-to-resident sexual abuse) should not have happened.</p> <p>During an interview on 2/6/25 at 3:05 PM, CNA M reported that she last saw R1 in the dining room at dinner time (approximately 6:15 PM). CNA M said she had just returned from the restroom when she heard yelling coming from R2's room. CNA M said she saw R1 on top of CNA B, R1's pant were around his ankles. CNA M said that R2 was naked on the bed, facing the door (on her right side) which was unusual for R2. CNA M said R2's brief was bunched up at the head of the bed, her clothes at the foot of the bed on the floor. CNA M said R2 had tears in her eyes and the bottom sheet at the top of the bed was wet with what appeared to be body fluids.</p> <p>Review of the facility Abuse Prohibition Policy last revised 9/2022 reflected To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an ongoing basis. It is the responsibility of all staff to provide a safe environment for the guests/residents. The policy defines sexual abuse Sexual Abuse is non-consensual sexual contact of any type with a guest/resident. Sexual abuse includes, but is not limited to: unwanted intimate touching of any kind especially of the breast or perineal area; all types of sexual assault or battery, such as rape, sodomy, fondling and/or intercourse or coerced nudity; forced observation of masturbation and/or pornography; and taking sexually explicit photographs and/or audio/video recordings of a guest/resident(s) and maintaining and/or distributing them (e.g. posting on social media). Guests/residents have the right to engage in consensual sexual activity. If at any time the facility has reason to suspect the guest/resident does not have the capacity to consent to sexual activity the facility should evaluate whether the guest/resident has the capacity to consent.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>29073</p> <p>Based on interview and record review the facility failed to review and revise the facility assessment.</p> <p>Findings:</p> <p>During an entrance conference interview with the Nursing Home Administrator (NHA) on 2/5/25 at 8:50 AM, the NHA reported the current census was 93 residents.</p> <p>Review of the Facility Assessment provided to the surveyor during the abbreviated survey reflected the assessment was based on a Resident Population Profile from July 11, 2023-July 10, 2024. At this time, the average daily census was 73 residents. The assessment had not been updated to reflect the increased census and acuity. A Core Staffing and Personnel Audit attached to the assessment had not been reviewed since August 6, 2024 .</p> <p>Further review of the facility assessment indicated the NHA and the Director of Nursing (DON) had not been updated to reflect individuals currently in those roles, which had changed since July 10, 2024.</p> <p>During an interview on 2/5/25 at 1:28 PM, the NHA reported she had been the facility Administrator for 90 days and did not know she needed to update the Facility Assessment.</p>