Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 02/04/2026
NAME OF PROVIDER OR SUPPLIER: Regency at Fremont		STREET ADDRESS, CITY, STATE, ZIP CODE: 4554 West 48th Street 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2715766Based on interview and record review, the facility failed to promptly identify a change in condition and act upon those changes for 1 resident (Resident #6) out of 3 residents reviewed for quality of care, resulting in a delay in medical treatment and surgical intervention for an unstable sacral fracture with spinopelvic dissociation and left superior/inferior ramus fractureFindings:Resident #6 (R6)Review of an admission Record revealed R6 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: sacral and pelvic fractures from fall and Parkinson's Disease.Review of a Minimum Data Set (MDS) assessment for R6, with a reference date of 11/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated R6 was cognitively intact. Review of R6's Kardex revealed: Monitors: report to Nurse s/sx (signs and symptoms) of (the) following.change in normal behavior.decline in ability to help with/do adls (activities of daily living), continence. Transferring: (R6) requires one assistance with gait belt and 2ww (wheeled walker) for stand and pivot transfers.Review of a Complaint/Incident Investigation Report reported to the State of Michigan revealed R6 experienced a fall on 11/14/25 while receiving care from Certified Nursing Assistant (CNA) G. The complainant states CNA G told the resident not to tell anyone what happened. The complainant states that for 5 days the resident was in such bad pain that she couldn't sit in her wheelchair.the resident was sent to (name omitted) hospital and found to have a separated pelvis and her spine separated from her sacrum.the resident was sent to (name omitted) Hospital Trauma Center and had to have a 4-hour surgery to try to correct the damage. The complainant states the resident may never walk again.Complainant states when he inquired about the residents' change in condition, CNA G told him that nothing happened to her while the resident was on her watch. The complainant states this was reported to Licensed Practical Nurse (LPN) F the charge nurse, but he doesn't know if an internal investigation was completed or if the incident was reported.During an interview on 02/02/2026 at 12:55 PM, Family Member (FM) C reported that R6 had told him that she fell in the shower on 11/14/25. R6 reported to FM C that the aide told her not to tell facility staff that it had happened. FM C then asked R6 to point out the aide that was involved and she pointed to CNA G. FM C reported he asked CNA G about the alleged fall and she reported that R6 had not fallen and if she did, then she was not the aide that was with her. FM C reported he visited R6 that weekend (11/15/25 and 11/16/25) and R6 was in increased pain. He reported that on 11/17/25 he visited R6 and she had increased confusion. FM C reported that the nurse, LPN F, reported she was going to get R6 up to the bathroom and FM C asked if he could watch how she transferred R6 since he would need to do it by himself at home. LPN F allowed him to watch and when LPN F pulled down R6's pants they noticed a large bruise on her right hip. FM C reported to LPN F that it was likely related to R6's fall on 11/14/25 and stated (LPN F) freaked out and reported that she did not know that R6 had fallen. FM C reported R6 was then sent to the emergency room and was (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 0684 Level of Harm - Actual harm Residents Affected - Few	Indicating a change in her functional ability and the identification of new/increased pain.Review of R6's Electronic Medical Record revealed no documentation that LPN F notified the provider or management of the large bruise/injury observed or the allegation of a fall on 11/14/25 following her interaction with FM C on 11/17/25.Review of a Provider Note dated 11/18/25 at 8:00 AM revealed, Follow up after ED visit. Pt (patient) states that she is having sciatica pain on her right side.Sciatica, right side: Started a week ago, is not improving. Started on gabapentin (analgesic medication).Review of R6's Electronic Medical Record revealed no documentation that a comprehensive physical assessment was completed following R6's change of condition: documented change in functional ability (required the use of a sit to stand), the new onset right sciatic pain (11/16/25), newly identified injury (11/17/25 by LPN F), or the need for an additional pain medication (gabapentin).Review of R6's Nurses Note dated 11/18/2025 at 6:05 PM revealed, Resident reported to the nurse on 11/18/2025 at 5:55pm that she had a fall on 11/14/2025. When asked what time this occurred she could not give a specific time, just that it happened sometime between lunch and dinner. Resident stated that she was standing at the bathroom bar when she fell to her right side and landed in the shower stall. When asked how or who got her up off the floor she stated that a (name omitted) lifted her back into her wheelchair. Upon assessment of the resident it was noted that there was a hematoma to residents lower back with a bruise that surrounded it and continued down the right thigh. The area around the bruise shows signs of healing with yellow and green areas. No other skin issues noted or observed. VSS (vital signs stable). No c/o (complaints of) pain and or discomfort from baseline complaints. (R6 had experienced a change in pain documented on 11/16/25 and a pain medication was ordered that morning.)Review of R6's Nurses Note dated 11/19/2025 at 07:00 AM revealed, Upon assessment of residents lower back, there is a bruise that is located along the lower back and down the right thigh. It has spread from a site of a hematoma that can be felt under the skin. Around the edges of the bruise it has already started to heal and shows signs of being yellow/green in color. When asked where this bruise came from resident states it is from a previous fall. When asked if this resident has any pain resident states no. Upon palpitation of bruised area resident shows no s/s of pain and/or discomfort.Review of R6's Incident Report for a fall on 11/14/25 at 3:00 PM revealed the Nursing Home Administrator (NHA), Director of Nursing (DON), and Physician were notified of the fall on 11/18/25 at approximately 6:00 PM.Review of R6's Task Documentation revealed R6 received care from CNAs multiple times throughout each day with toileting, personal hygiene, and dressing which would have exposed the skin on R6's lower body. Additionally, R6 received a shower on 11/16/25 which would have exposed the entirety of her skin in a well-lit area.Review of R6's Electronic Medical Record revealed no documentation that the facility CNAs notified a licensed nurse or management of the significant bruising on R6's right hip. There was no documentation that a licensed nurse documented an assessment of the injury or notified the provider or management.Review of R6's Care Plan dated 11/7/25 revealed, (R6) is occasionally incontinent of Bladder. There were no entries/focus areas that R6 experienced bowel incontinence indicating that was not an active problem.Review of R6's Urinary Continence documentation completed on each shift (3 times a day) revealed:From 10/30/25 through 11/13/25 there were 13 entries of incontinence out of a total of 45 entries.From 11/14/25 through 11/19/25 there were 14 entries of incontinence out of a total of 16 entries. R6 was only continent of bladder for 1 shift on 11/14/25 and 11/17/25.Review of R6's Bowel Continence documentation completed on each shift revealed:From 10/30/25 through 11/13/25 no documentation of bowel incontinence out of 7 entries.From 11/14/25 through 11/19/25 there were 4 entries of bowel incontinence out of a total of 6 entries.Review of R6's Electronic Medical Record revealed no documentation that the CNAs or licensed nurses identified a significant (continued on next page)

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