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	05/06/2026

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. This citation is related to intake #2741450Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 7 of 25 residents reviewed for accommodation of needs. Findings:During an observation on 05/04/26 at 5:00 AM, the resident in bed 100-1 laid resting in bed with her eyes closed and the call light touch pad hung over the back of the head board, out of sight and out of reach of the resident. The resident in bed 100-2 laid in bed resting with her eyes closed and the call light was curled up on top of the blanket at the foot of the bed out of sight and out of reach of the resident.During an observation on 05/04/26 at 5:02 AM, the resident in bed 104-1 laid resting in bed with her eyes closed and the call light sat on the floor at the head of the bed, out of sight and out of reach of the resident. During an observation on 05/04/26 at 5:04 AM, the resident in bed 105-1 laid resting in bed with her eyes closed and the call light sat on the floor between the bed and the wall, out of sight and out of reach of the resident.During an observation on 05/04/26 at 5:07 AM, the resident in bed 106-1 laid resting in bed with her eyes closed and the call light sat on the floor between the bed and the wall, out of sight and out of reach of the resident.During an observation on 05/04/26 at 5:14 AM, the resident in bed 310-1 laid resting in bed with her eyes closed and the call light sat on the floor on the right side of the bed, out of sight and out of reach of the resident.During an observation on 05/04/26 at 5:26 AM, the resident in bed 208-2 sat in a wheelchair positioned near the foot of the bed, resting with her eyes closed and slumped over to her right. The privacy curtain was pulled and the resident could not be observed from the hallway and the call light wrapped around the head of the bed out of sight and out of reach of the resident.During an interview on 05/04/26 at 9:20 AM, certified nurse aide (CNA) N indicated that the expectation was for staff to make sure call lights were within reach of the resident's each time staff enter the room. Review of the facility policy Call Lights, last reviewed on 03/12/25, revealed .when a resident is in bed or confined to a chair ensure the call light is within easy reach for the resident.

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2984523Based on interview and record review, the facility failed to (a) adequately monitor for medication side effects, (b) prescribe medications with an adequate/correct indication, and (c) frequently monitor and re-assess the effectiveness of the medications for one of three residents (Resident #100) reviewed for unnecessary medications. Findings:Resident #100 (R100)Review of an admission Record revealed R100 was a [AGE] year-old female, admitted to the facility on [DATE], with facility diagnoses of dementia, alcohol abuse with alcohol-induced mood disorder, and alcohol use, unspecified with alcohol-induced persisting dementia. During a telephone interview on 05/03/26 at 4:23 PM, Family Member (FM) T stated that almost two years ago R100 had genetic testing done for early onset Alzheimer's. R100 had the APOE-e4 marker with two copies which were very rare genetic markers. The testing was done due to R100 not acting like herself for some time, she lost her job due to poor performance that built up slowly over a couple of years, was forgetful most the time, would wander from the house, and would get mean towards family members. We thought she had a brain tumor or something, nobody could figure out what was the matter with her. After the testing, R100 was started on medication for Alzheimer's and lived at home with her husband until recently when he could no longer keep her from leaving the house and would be found walking in very busy streets. The husband took R100 to a local acute care hospital in search of help. R100 was admitted to the hospital from [DATE] until she was admitted to the skilled nursing facility sixteen days later on 10/20/25.According to the National Institute on Aging, .one well-known gene that influences Alzheimer's risk is the apolipoprotein E (APOE) gene. APOE comes in several forms called alleles (e.g. E2, E3, E4). APOE-E4 increases the risk for Alzheimer's and is associated with early age of disease onset. About 15% to 25% of people have this allele, and only 2% to 5% carry two copies. www.nia.nih.gov/alzheimers.Review of a History & Physical completed at the hospital on [DATE], reflected that R100 was diagnosed with dementia-Alzheimer's early on-set with behavioral disturbance and wandering behavior and a history of alcohol abuse. Review of a hospital Discharge Summary for R100 on 10/20/25, reflected the following medication orders: Memantine 10 mg (milligrams) one tab twice daily and Donepazil 10 mg one tab at bedtime (both medication previously prescribed prior to hospitalization to treat dementia), Seroquel 200mg one tab twice daily (an antipsychotic newly prescribed at the hospital to help treat the behavior disturbances associated with the dementia), and Ativan (lorazepam) 0.5 mg one tab twice daily (a benzodiazepine newly prescribed at the hospital to help reduce anxiety and agitation associated with the dementia).Review of nursing Progress Notes for R100 and dated 10/20/25 reflected: (a) resident arrived at the facility at 1:45 PM, (b) stated that she did not want to be there and threatened her husband if he left her there, (c) was difficult to redirect, called staff names, physically lashed out at staff, (d) was placed on a 1:1 (one staff person assigned to the resident), and (e) was given an injection of Haldol (an antipsychotic) 5 milligrams (mg) for psychosis, prescribed by Nurse Practitioner (NP) J.Review of a prescriber Progress Note dated 10/21/25 and written by Nurse Practitioner (NP) J reflected the following information was obtained from old medical records and nursing staff: (a) (R100) suffers from Alzheimer's dementia with behavioral disturbance and becomes combative at times, (b) height 5' 3 and weight 103.8 pounds, (c) physical exam findings-appears comfortable, negative for confusion or falls, and is agitated, (d) Assessment and Plans-increased Ativan to compensate for ETOH (alcohol) withdrawals. (R100 had been at a hospital for 16 days prior to being admitted to the nursing facility and had not consumed alcohol).According to the National Institute on Alcohol Abuse and Alcoholism, symptoms of alcohol withdrawal begin 6 to 24 hours from the last use.A review of R100's Electronic Health Record (EHR) revealed there was no information that indicated R100 was in acute alcohol withdrawal, when her last alcohol consumption was (R100 had been in the hospital since 10/04/25), how long R100 had been consuming alcohol (days, months, years etc), and how much (quantity) and (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what (beer, liquor etc) had been consumed. According to the World Health Organization, benzodiazepines (Ativan) are recommended as the front-line medication for the management of alcohol withdrawal in alleviating alcohol discomfort and preventing seizures and delirium .the duration of benzodiazepine treatment should be limited to the first 3 to 7 days after stopping alcohol intake. who.int/teams/mental-health and substance use/treatment-care.Review of an Electronic Medication Administration Record (E-mar) for R100 dated 10/01/25 to 10/31/25 reflected an order to increase Ativan from 0.5 mg twice daily to 1 mg three times daily, starting 10/22/25 and ordered by NP J. This medication change tripled the dose of Ativan prescribed daily to R100. The order did not include a stop date within 3-7 days. Review of an Electronic Medication Administration Record (E-mar) for R100 dated 10/01/25 to 10/30/25 reflected (a) an order on 10/23/25 for R100 to start Depakote 125 mg three times daily for mood stabilization and (b) an order to discontinue Donepazil (a medication the resident had been taking long term for dementia), ordered by NP J. Review of R100's progress notes revealed NP J did not see nor assess the resident on 10/23/25 prior to starting the new medication (Depakote) and discontinuing the Donepazil. Review of nursing Progress Notes for R100 revealed after a note entered into the record on 10/25/25 at 1:48 AM, there were no additional nursing notes regarding assessments or observations made during the rest of the day on 10/25/25, 10/26/25 and 10/27/25. Review of a nursing Progress Note dated 10/28/25 reflected nursing requested for R100 to be seen by a contracted psychiatric specialist. R100 was not seen by the psych specialist until 11/08/25 (11 days after the request was made by nursing).Review of an E-mar for R100 dated 10/01/25 to 10/30/25 revealed an order on 10/28/25 to increase Seroquel from 200 mg twice daily to 300 mg twice daily. This medication increase was ordered by NP J. Review of R100's progress notes revealed NP J did not see nor assess the resident on 10/28/25, prior to increasing this medication and last saw and assessed R100 on 10/21/25. Review of a History and Physical (H&P) completed on 10/29/25 by Medical Doctor (MD) U revealed: (a) evaluating today for regulatory H&P visit, (b) incorrectly listed Donepazil as a current medication (was discontinued on 10/23/25 by NP J), (c) incorrectly listed the dose of Ativan as 0.5 mg one tab twice daily (Ativan was increased to 1 mg three times daily on 10/21/25 by NP J with an indication of acute alcohol withdrawal and no stop date), (d) did not list Depakote as a current medication (started on 10/23/25 by NP J), and (e) incorrectly listed the dose of Seroquel as 200 mg one tab twice daily (was increased to 300 mg twice daily on 10/28/25 by NP J). Review of a prescriber Progress Note for R100 dated 10/30/25 and written by NP J reflected the following regarding R100's current state: (a) positive for fatigue and low energy, (b) positive for loss of bladder control, (c) positive for falls and weakness (no documentation of the resident falling could be located in the electronic health record (EHR), and (d) NP J documented this patient's dementia was caused by the alcohol abuse. (Despite R100's positive APOE-e4 marker for early onset Alzheimer's)Review of nursing Progress Notes revealed no nursing notes regarding nursing assessments nor nursing observations of R100 on 10/29/25, 10/30/25, 10/31/25, 11/01/25, 11/02/25, 11/03/25, and 11/04/25. Review of a prescriber Progress Note for R100, dated 11/06/26 and written by NP J revealed: (a) resident was throwing lunch trays and hitting other residents, (b) resident received a Haldol injection 5 mg for the violent outbursts, (c) was positive for weight loss, (d) positive for confusion and falls, and (e) positive for tachycardia (increased heart rate). During an interview on 05/05/26 at 11:20 AM, the Administrator stated that there was no record/documentation of R100 throwing lunch trays or hitting other residents during her 27 day stay at the facility. Review of R100's EHR revealed an unwitnessed fall documented at 4:45 PM on 11/06/25.Review of nursing Progress Notes revealed no nursing notes regarding nursing assessments nor observations of R100 on 11/09/25 and 11/10/25. Review of an E-mar for R100, dated November 2025, revealed a new order for Risperdal Consta (an antipsychotic) intramuscular injection 12.5 mg every 14 days. The first injection of Risperdal Consta was given 11/11/25. Review of R100's EHR revealed an unwitnessed fall on 11/11/25 at 3:35 PM. Review of R100's EHR revealed an unwitnessed fall on 11/15/25 at 2:30 PM.Review of the E-mar's for R100 dated October and November 2025 reflected orders for direct care (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff to monitor the resident twice daily for side effects of the Seroquel, Ativan, and Depakote i.e. appetite changes, blurred vision, confusion, dizziness, weight changes, nausea, drowsiness, fatigue, sedation, involuntary movement. If R100 had no side effects, nursing would document that by indicating 0 on the E-mar's. If side effects were observed, nursing would document that by entering the number that corresponded with each specific side effect (for example-the number 3 would be documented if R100 experienced drowsiness that shift). No side effect documentation was completed starting the evening of admission [DATE]) until the time R100 was hospitalized (the morning of 11/16/25) as evidenced by staff placing a check mark on the E-mar's and not correctly following the order. Review of the Behavior Monitoring task documentation for R100, completed by certified nurse aides (CNA's), reflected any behaviors such as, abusive language, threatening behavior, kicking and hitting, yelling or screaming, wandering, refusing care. The following behaviors were documented from 11/01/25 to 11/16/25: *11/01/25- no documented behaviors *11/02/25-behaviors noted only in the evening *11/3/25- only wandering documented *11/04/25- no documented behaviors *11/05/25- no documented behaviors *11/06/26- behaviors noted only in the evening *11/07/26- no behaviors documented *11/08/25- behaviors noted only in the evening *11/09/25- behaviors only in the evening *11/10/25- behaviors only in the evening *11/11/15- only wandering in the evening documented *11/12/25- no behaviors documented *11/13/25- no behaviors documented *11/14/25- only behaviors with AM care documented *11/15/25- wandering and refusing care documented *11/16/25- no behaviors documentedDuring an interview on 05/05/26 at 11:35 AM, employee K recalled R100 as having very bad dementia, talked to pictures on the wall, would try to put on lipstick and it would be all over her face, walked the halls all the time, and declined very quickly in the last week or two; slept a lot and stayed in her room. Employee K reported seeing R100 at least 4-5 times a week during the resident's stay. During an interview on 05/05/26 at 11:40 AM, employee F recalled R100 as walking around all the time, wasn't very nice to the staff, nonsensical talk sometimes, and only worked with R100 a few times. During an interview on 05/05/26 at 11:47 AM, employee C recalled R100 as the alcoholic, was very busy on the unit and hard to redirect, went in and out of other resident's rooms, had a rapid decline over the last week R100 was there and was very lethargic the day R100 went to the hospital. During an interview on 05/05/26 at 11:51 AM, employee E recalled R100 as very busy and aggressive then there was a big change and a few days after that the resident was sent to the hospital. Employee E did not recall any other specifics. During an interview on 05/05/26 at 12:00 PM, employee G recalled R100 as having alcohol issues, became angry quickly, walked around a lot, could be uncooperative, and did not remember any other specifics. During an interview on 05/05/26 at 12:10 PM, employee L recalled R100 as a severe alcoholic, very busy, looked totally normal, and very active when she first got to the facility and then could barely keep her eyes open, would sit on the floor with her (R100) knee's bent and rock back and forth, started falling a lot, was pretty out of it, and declined quickly.During a telephone interview on 05/05/26 at 10:30 AM, NP J stated that the increase to R100's Ativan on 10/21/25 was due to withdrawal symptoms and any information used to make the medication change was found in R100's EHR. I wanted to take the edge off so she wouldn't have behaviors. NP J remembered R100 as very agitated, refused staff care, and wandered all the time. NP J did not recall the reason for the increase in Seroquel on 10/28/25 nor recall the reason for discontinuing the Donepazil on 10/23/25. NP J revealed not having access to R100's EHR due to being terminated from the facility and its governing corporation. Review of R100s EHR revealed no documentation that the behavioral management team implemented a dose reduction and/or discontinuation of R100's Ativan, Seroquel, and Depakote despite R100's confusion, increase in falls and an inadequate indication for the use of the psychotropic medications. Review of nursing Progress Notes for R100 dated 11/16/25 revealed:(a) at 12:49 AM no concerns were noted, (b) at 8:56 AM R100 was noted to have diarrhea, a fever, was weak, decreased mobility, had abnormal lung sounds, seemed different than usual, there was a noted change in skin color, (c) at 10:16 AM R100 was noted to have shortness of breath, pulse 122, respirations 34, temperature 100.8, and pulse oximetry 55% on (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room air.Review of an EMS (ambulance) run record for R100,dated 11/16/25, (information obtained from facility staff) revealed (a) patient had a norovirus type illness for 24 hours and has been vomiting, (b) lung sounds altered with audible rhonchi (a low pitched, course, rumbling, snore like sound heard during breathing) with suspected aspiration pneumonia, (c) patient found unresponsive, (d) staff reported patient has been hypoxic (low oxygen in the blood) and supplemental oxygen has not improved her, temperature is 101. Review of a physician emergency room note for R100, dated 11/16/25 revealed the following: (a) gurgling heard on respirations, (b) is critically ill appearing, (c) has copious amounts of what appears to be vomit in her mouth, as well as her ears and recess of the collar bone, and (d) mucous membranes are dry. This patient was brought in due to altered mental status, fever, and trouble breathing. Apparently some kind of viral gastrointestinal illness has been going on were people have been vomiting and the patient had been vomiting and was found this morning with trouble breathing. Patient has pretty severe dementia. No active vomiting in the ambulance. Review of a Drug Interaction Report which included Ativan (lorazepam) Depakote (divalproex sodium), Haldol (haloperidol), Risperdal Consta (risperidone), and Seroquel (quetiapine)The recommended maximum number of medicines in the 'CNS drugs' category to be taken concurrently is usually three. Your list includes five medicines belonging to the 'CNS drugs' category:Ativan (lorazepam)Depakote (divalproex sodium)Haldol (haloperidol)Risperdal Consta (risperidone)Seroquel (quetiapine)The recommended maximum number of medicines in the 'psychotropic agents' category to be taken concurrently is usually three. Your list includes four medicines belonging to the 'psychotropic agents' category: Ativan (lorazepam)Haldol (haloperidol)Risperdal Consta (risperidone)Seroquel (quetiapine)The recommended maximum number of medicines in the 'antipsychotics' category to be taken concurrently is usually one. Your list includes three medicines belonging to the 'antipsychotics' category:Haldol Decanoate (haloperidol)Risperdal Consta (risperidone)Seroquel (quetiapine)Major Drug interactions (Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit.) Haldol (haloperidol) & Risperdal Consta (risperidone) Haldol (haloperidol) & Seroquel (quetiapine)Haloperidol can cause dose-related prolongation of the QT interval. Theoretically, coadministration with other agents that can prolong the QT interval may result in additive effects and increased risk of ventricular arrhythmias including torsade de pointes and sudden death In addition, if combination therapy with agents with anticholinergic properties is required, caution is advised, particularly in the elderly and those with underlying organic brain disease.Moderate Drug InteractionsHaldol (haloperidol) & Ativan (lorazepam)Haldol (haloperidol) &, Depakote (divalproex sodium)Ativan (lorazepam) & Risperdal Consta (risperidone)Central nervous system- and/or respiratory-depressant effects may be additively or synergistically increased in patients taking multiple drugs that cause these effects, especially in elderly or debilitated patients. Sedation and impairment of attention, judgment, thinking, and psychomotor skills may increase .During concomitant use of these drugs, patients should be monitored for potentially excessive or prolonged CNS and respiratory depression. Cautious dosage titration may be required, particularly at treatment initiation.Ativan (lorazepam), Depakote (divalproex sodium)Close observation for clinical evidence of benzodiazepine toxicity (excessive sedation) is recommended if valproate and a benzodiazepine must be used together.Ativan (lorazepam) & Seroquel (quetiapine)quetiapine may enhance the CNS effects of lorazepam .The clinician may consider closer clinical monitoring of the patient for lorazepam toxicity if quetiapine and lorazepam are coadministered. Patients should be advised to notify their physician if they experience symptoms such as excessive sedation, confusion, dizziness, or incoordination.Risperdal Consta (risperidone) & Depakote (divalproex sodium)clinicians may consider monitoring the pharmacologic response and serum valproate levels more closely whenever risperidone is added to or withdrawn from therapy. Ambulatory patients should be made aware of the possibility of additive central nervous system effects (e.g., drowsiness, dizziness, lightheadedness, confusion)Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, One of the greatest challenges for older adults is safe (continued on next page)

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