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	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent (5%) for 1 of 8 residents (R34) observed during the medication administration task, resulting in a medication error rate of 7.41%. Findings include: A review of R34's admission Record, dated 6/8/25, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R34's admission Record revealed they had multiple diagnoses that included dementia. During a medication administration observation on 6/8/26 at 7:35 AM, Registered Nurse (RN) B administered multiple medications to R34, including folic acid 400 micrograms (mcg) (1 tablet) and magnesium oxide 400 milligrams (mg) (1 tablet). RN B verbalized the medications, doses, and quantities of the tablets. A review of R34's Medication Administration Record (MAR), dated 6/1/26 to 6/8/26, revealed R34 was to receive folic acid 1 mg at 8:00 AM. However, RN B only administered 400 mcg (0.4 mg) of folic acid to R34. A review of R34's Medication Administration Record (MAR), dated 6/1/26 to 6/8/26, revealed R34 was to receive magnesium oxide 400 milligrams 2 tablets at 8:00 AM. However, RN B only administered 1 tablet of magnesium oxide to R34. During an interview on 6/8/26 at 12:33 PM, RN B verified she administered folic acid 400 mcg to Resident #34 at 7:35 AM. During an interview on 6/8/26 at 4:45 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were notified of the medication errors that occurred during the medication administration task. A review of the facility's Medication Administration policy and procedure, revised 10/17/23, revealed the nurse is to verify the medication label against the medication administration record for resident name, time, drug, dose, and route.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This site pertains to the annual survey and Intake 3017765.Based on observation, interview and record review, the facility failed to maintain appropriate hot food temperatures and failed to serve palatable/quality food items for residents eating food prepared in the kitchen.Findings include:During an interview on 6/08/26 at 3:02 PM, Complainant J revealed a concern about the poor quality and lack of food being served. Complainant J stated, There is often not enough food on the plate. What is being served is horrible and unappetizing. Complainant J further revealed she brought in meals practically daily to ensure her resident, ate at least one decent meal a day. During a kitchen observation on 6/08/26 at 11:43 AM, [NAME] K was observed taking temperatures prior to plating resident food from the steam table. A large hotel pan of what looked like pureed sausage gravy was temped at 155 degrees. [NAME] K revealed thick white gravy substance was beef stroganoff. The noodles in the next large pan looked to overcooked noodles.Further observation of [NAME] K plating resident meals revealed tongs were being used to inconsistently portion noodles onto resident plates. Portion sizes ranged from less than the size of a deck of cards to sometimes twice the size.On 6/8/26 at 12:50 PM, a food tray was obtained from the 200-Hallway. The tray sampled contained a 54-degree side salad, 2 64-degree glasses of chocolate milk and a roll. Beneath the covered lid was a plate that was cool to touch and portion of beef stroganoff that was just bigger than a deck of cards. The noodles were cold, bland/flavorless and overcooked. This surveyor couldn't tell if there were mushrooms in the pasty white looking stroganoff. The stroganoff did not have chunks of meat, rather ground up bits of meat that had no flavor. The not warm, bland, flavorless stroganoff temped at 121 degrees.On 06/09/2026 at 12:41 PM, another lunch tray was pulled to check for food quality/palatability. At 12:43 PM the following temperatures were obtained from a resident tray on the 200-hallway cart (the last resident trays to be served). The following items were noted: the plate was cool to touch. A scoop of al [NAME] carrots temped at 99.9 degrees, six seasoned potato wedges temped at approximately 102 degrees, with 4 chicken nuggets (bigger than a quarter but smaller than a 50-cent piece) temped out at 111 degrees. The chicken nuggets had a wet, gummy, chewy texture that was completely unappetizing. On 6/9/26 at 12:50 PM, two anonymous residents (residents who did not want to be mentioned) were observed eating in a dining area. Both residents stated that the lunch was not great today, and that it was pretty awful most of the time. Resident A had eaten an individual container of ice cream, one bite of chicken and a few fries because they were cold and did not taste good. Resident B revealed, My lunch was not good. The chicken was tough; and my fries were kind of cold. Both residents stated the food here does not taste very good.Review of Resident A and Resident B's Electronic Medical Record (EMR) reflected weight loss but not significant weight loss at this time. During an interview to go over some concerns on 6/09/2026 at 1:00 PM, the Nursing Home Administrator (NHA) stated, I thought there was a problem with food palatability. During an interview on 6/9/26 at 3:05 PM, the NHA reported that the facility was aware there were concerns about food palatability. The NHA said that the facility had just started a Food Council (a group of interested residents who would meet monthly to discuss food and dining) two months ago, but there was still work to be done to increase resident satisfaction.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the use of and utilize personal protective equipment for three of three residents (Resident #102, Resident #69, and Resident #70) reviewed for infection control and failed to clean glucometers according to manufacturer guidelines. Findings:Resident #102 (R102) Review of a Face Sheet revealed R102 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnoses of acute kidney failure. Review of an admission Nursing Comprehensive Evaluation completed 06/06/26 revealed the following observed skin concerns: (a) Groin-open boil with dressing to left groin, (b) Coccyx-unstageable pressure injury, and (c) Abdomen-bilateral open boils to folds. During an observation on 06/07/26 at 3:01 AM, no PPE (personal protective equipment) sat near the room for staff to utilize during close contact care nor was a sign posted near the resident's room alerting staff of the need to utilize enhanced barrier precautions. During an observation on 06/08/26 at 2:50 PM, no PPE (personal protective equipment) sat near the room for staff to utilize during close contact care nor a sign was not posted near the resident's room alerting staff of the need to utilize enhanced barrier precautions (EBP's). During an interview on 06/08/26 at 3:20 PM, the Director of Nursing (DON) indicated that EBP's (enhanced barrier precautions) could be initiated by any nursing staff without a physician order. Resident #69 (R69) Review of a Face Sheet revealed R69 was an [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of a second degree burn to the left thigh and Alzheimer's dementia. Review of an admission Nursing Comprehensive Evaluation completed 05/15/26 revealed the following skin concerns: (a) stage 2 pressure injuries to bilateral buttocks, (b) a burn injury to the left thigh, and (c) a burn injury to the right thigh. During an observation on 06/09/26 at 7:24 AM, certified nurse aide (CNA) H assisted R69 to the bathroom and did not utilized personal protective equipment for enhanced barrier precautions (EBP). Resident #70 (R70) Review of a Face Sheet revealed R70 was a [AGE] year-old male admitted to the facility on [DATE] with pertinent diagnoses of a stage 3 pressure ulcer to the sacral area, vascular dementia, and a stroke that caused left-sided weakness and paralysis. During an observation on 06/08/26 at 4:12 PM, Certified Nurse Aide (CNA) E and CNA F provided care to R70 and did not utilize PPE for EBP. During an observation on 06/08/26 at 4:15 PM, a sign hung at the entrance to R70's room alerting staff that Enhanced Barrier Precautions were to be used when providing direct and close contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident care. Review of the facility policy Enhanced Barrier Precautions (EBP), last reviewed 03/05/25, reflected: It is the intent of this facility to use Enhanced Barrier Precautions (EBP) in addition to Standard Precautions for preventing the transmission of CDC targeted multidrug-resistant organisms (MDRO's) .Enhanced Barrier Precautions are indicated for residents with a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO and should remain in place for the duration of the resident's stay or until the resolution or the wound or discontinuation of the indwelling medical device. During an observation on 6/7/26 at 4:45 AM, Licensed Practical Nurse (LPN) T performed a blood glucose check on R54. After she performed the procedure, she cleaned the glucometer machine with an alcohol pad from the top drawer of her medication cart. During an observation on 6/7/26 at 4:50 PM, LPN T performed a blood glucose check on R101. After she performed the procedure, she cleaned the glucometer machine with an alcohol pad from the top drawer of her medication cart. During an interview on 6/8/26 at 12:50 PM, Registered Nurse (RN) B stated she cleans the glucometer machine with [name brand] germicidal wipes after each use. She stated she thought the wait time was 10 minutes. During an interview on 6/9/26 at 9:25 AM, LPN C stated she cleans the glucometer machines with an alcohol pad between each resident use. She stated she makes sure the machine is completely wiped down with the pad and when it dries, it dries. During an interview on 6/9/26 at 10:00 AM, RN D stated he cleans the glucometer machine with purple wipes (color of the lid to the container of the [name brand] germicidal wipes) after each use. He stated he wraps the machine in a cloth and lets it sit for 2 minutes to make sure the machine is disinfected. During an interview on 6/9/26 at 1:00 PM, the Director of Nursing/Infection Control Preventionist (DON/ICP) stated staff are supposed to clean the glucometers with bleach wipes after each use. She stated alcohol pads/wipes are not appropriate. A review of the user's manual for the brand of glucometer that the facility uses, dated 4/24, revealed there are four disinfection/germicidal wipes that are approved for use with the brand of the glucometer that the facility uses (the [name brand] germicidal wipes that the facility had in their medication carts was not one of them). It also states other EPA (Environmental Protection Agency) registered wipes may be used for disinfectiong the [name brand of glucometer], however, these wipes have not been validated and could affect the performance of your meter. A review of the lable for the [name brand] germicidal wipes that the facility had in their medication carts, this brand of germicidal wipe was listed as an EPA registered wipe that can be used to clean and disinfect blood glucose meters (glucometers). The label also revealed that it takes 2 minutes for the wipe to disinfect an object.