STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235260	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Waterford	1901 N Telegraph Rd Waterford, MI 48328

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. This citation pertains to intake(s): MI00151872 Based on interview and record review, the facility failed to implement the abuse policy that requires a complete background check for newly hired staff for one (Staff C) of three staff members reviewed for background checks/abuse. Findings include: A review of Licensed Practical Nurse (LPN) C was completed during the survey as part of an abuse investigation. LPN C was hired on 3/18/25. Review of their personnel file revealed background screening reports and fingerprint appointment date of 3/20/25. The screening report did not indicate that fingerprints for LPN C had been performed based on the documents that were in the personnel file. An interview with Human Resource (HR) coordinator E was completed on 4/10/25 at approximately 4PM. They were queried about the fingerprints for LPN C. They reported that they had kept the fingerprints on a separate binder, and they would check. Later they came and reported that that they did not have any fingerprints completed for LPN C and they added that the staff member was scheduled to go for their appointment on 3/20/25 but they did not go. They added they checked weekly and followed up weekly to track. They were queried about the LPN C workdays, and they reported LPN C was on orientation 3/18/25 and 3/19/25; they were in training at the facility on 3/25/25, 3/26/25, 3/31/25 and 4/4/25. At approximately 4:40 PM the Administrator/Abuse Coordinator was notified of the concern regarding the fingerprint for LPN C. They reported that LPN C was on orientation/training and they understood the concern. According to the State of Michigan Long Term Care Workforce Background Check Consent and Disclosure revealed MCL [Michigan Compiled Law] 333.20173a, MCL 330.1134a, and MCL 440.734b require that a health facility/agency that is a .nursing home .Shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the health facility/agency or AFC [Adult [NAME] Care] until the health facility/agency or AFC conducts a fingerprint-based criminal history check. An individual who applies for employment either as an employee or as an Independent contractor or for clinical privileges with a health care facility/agency or AFC and has received a good faith offer of employment, an independent contract, or clinical privileges shall give written consent at the time of application for the health care facility/agency or AFC to conduct a criminal history check, including a state and Federal Bureau of Investigation (FBI) fingerprint-based check, and shall give a written statement disclosing that he or she has not been convicted of a crime that would prohibit employment .The health facility/agency or AFC .Must retain verification of compliance with background check requirements.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake(s): MI00151872, MI00151053 Based on interview and record review, the facility failed to timely report allegations of abuse to the abuse coordinator and State Agency for two (R501 and R503) of two residents reviewed for abuse. Findings include: A facility reported incident was submitted to the State Agency on 2/26/2025 at 10:17 AM that revealed on 2/23/25 a family member visiting R503 was notified by R503 that a staff member had thrown a washcloth or towel at them earlier that day. The Family member notified R503's charge nurse of the allegation. The charge nurse failed to notify the abuse coordinator timely resulting in the failure of the Facility to notify the State Agency and initiate an investigation timely. An initial report of this allegation was submitted to the State Agency on 2/26/25, approximately 64 hours after the allegation was reported to the staff member by a family member. Review of the facility investigation report submitted to the State Agency revealed that abuse coordinator was notified of the allegation on 2/25/25 and local law enforcement was notified, and the investigation was initiated. An initial interview with the facility administrator was completed on 4/10/25 at approximately 8:45 AM. The administrator reported that the facility had identified that they were not in compliance due to late reporting by the staff member who was aware of the allegation regarding R503 on 2/23/25. They reported that they had completed a corrective measure and provided the documents in a binder. R501 A complaint received by the State Agency read in part, on the morning of 04/04/2025, there was an altercation between R501 (name omitted) and a staff member at the nursing home. R501 was agitated and did not want to take his medication. He and the staff member began to argue. A cup of water was thrown at R501 (name omitted) by the staff member . R501 was a long-term resident of the facility originally admitted on [DATE]. They were recently sent out to the hospital for aggressive behavior, and they were readmitted to the facility on [DATE]. R501's admitting diagnoses included, right below knee amputation, paranoid schizophrenia, diabetes and acute kidney failure. Based on Minimum Data Set (MDS) assessment dated [DATE], R501 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition. An initial observation and interview of R501 was completed on 4/10/25 at approximately 10:30 AM. R501 was observed in their room on their bed. R501 was queried about the incident that happened on April 4th and if they recall what happened. They reported that they got into an argument with a staff member. When queried further on what happened R501, reported that the nurse tried to through a cup of water on them. R501 added that the staff member was new, and they had never seen them before and provided the name of the nurse who was assigned to care for them that day (later verified with the facility provided schedule for accuracy). R501 also added that they did not believe that this staff member was a nurse, they were a Certified (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant (CNA), but the staff member was trying to give them their medications. R501 added that the facility called the police, and they did not do anything wrong and they knew better. Review of R501's Electronic Medical Record (EMR) revealed that on 4/4/25, R501 was petitioned and sent out to the hospital for aggressive behavior towards the facility staff. Local law enforcement was on the scene when R501 was petitioned and sent out to hospital. Review of hospital admission records from 4/4/25 revealed a psychiatry consult dated 4/6/25 that read in part, Patient states that he was in the room approach by a female nurse who was rude to him and threw water at him. He states that he subsequently swung at them .he has not been hostile or aggressive in previous incidents with staff .agitation state is acute reaction to exceptional (gross) stress. A follow-up interview with facility administrator was completed on 4/10/25 at approximately 11:20 AM. They were queried about the incident that led to petition and transfer R501 to the hospital on 4/4/25 and if they had any investigation reports. Administrator reported that they did not have any investigation report(s), and the nurse did not want to press any charges on the resident. They added that they were off that day and had come in a for a few hours and they were called to the Michigan Nurses Station where R501 was residing when this was happening and R501 had water on them and the nurse reported that R501 knocked the water cup. They were queried if anyone had spoken with R501 to find out what happened on 4/4/25 after the resident had returned or while they were out at the hospital and the Administrator reported that they did not. They were notified of the allegation and complaint related to the allegation which was confirmed by R501. At approximately 11:45 AM, the Administrator reported that they were going to speak with R501 and came back and confirmed the allegation with R501. The Administrator stated that they were reporting the incident to the State Agency. Review of the staff schedule for 4/4/25 revealed that Licensed Practical Nurse (LPN) C was in training/orientation under Registered Nurse (RN) B for their scheduled shift and LPN D was assigned to work on the other end of the unit/hallway. An interview with Director of Nursing (DON) was completed on 4/10/25 at approximately 12:15 PM. They confirmed that LPN C was on their last day of orientation with RN B. They were queried about the incident. They added that when LPN B went to give medications to R501 and LPN C touched R501 on their shoulder and the resident got upset and started swinging at her. They had to petition and send out R501 to hospital. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with RN B on 4/10/25 at approximately 1:25 PM. They were queried if they recalled the incident with R501 when they were sent out to the hospital. They reported that they did not witness the incident in the room as they were assisting another resident in the room. LPN C was on their last day of orientation. They added that they heard the noise in the hallway and when they came out of the room, they noticed R501 was extremely agitated and their coworker from the end of the hallway LPN D was trying to handle the situation. When queried if they were familiar with R501 they reported that they were. They were queried if they had ever witnessed R501 aggressive that way prior to this incident and they reported that they had not. When queried if they spoke with R501 and did they say anything, RN B reported that R501 mentioned about water splashed on them, when queried if R501 used the verbiage splashed or threw they reported that it could have been both and there was too much commotion, and they had to call the police. An interview with LPN D was completed on 4/10/25 at approximately 1:15 PM. LPN D was queried if they recalled the incident with R501. They reported that they heard the commotion in the hallway and saw LPN C running towards them stating that they cannot work like this and R501 was trying to hurt them. LPN D reported that they tried to calm R501 down. LPN D reported that R501 was very agitated and just reached and nicked their face when they attempting to calm the resident and stated (gender omitted) threw water on me. They reported that LPN D had mentioned that they were trying to give R501 medications and the resident got agitated when LPN D was trying to redirect R501 from drinking out of the faucet and water spilled. They added that they have worked on that unit and they had a good rapport with R501. When queried if they had seen R501 that aggressive/agitated prior to the incident, they reported they had not. They did not share why they did not report this allegation to the abuse coordinator. A follow-up interview with the Administrator was completed at approximately 3 PM and they were notified that R501 had alleged to their staff members that a nurse threw the water at them. The Administrator reported that they were unaware of the allegation until today and there was a lot going on with R501 that day, including their guardianship hearing. They were completing a report and initiating an investigation based on the time the surveyor had brought the incident to their attention on 4/10/25. A facility policy titled Abuse Prohibition Policy with a revision date of 9/9/22 read in part, To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents. Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative. The subject of abuse should be routinely and openly discussed. Guests/residents will be educated concerning the commitment of the facility to deal quickly and effectively with abuse or suspected abuse incidents on admission and at least annually thereafter. Staff members, volunteers, family members, and others shall immediately report incidents of abuse and suspected abuse and should be assured that they will be protected against repercussions. Abuse can be guest/resident-to-guest/resident, staff-to-guest/resident, family-to-guest/resident, visitor-to-guest/resident, etc.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 citation pertains to intake(s): MI00151919 Based on observation, interview, and record review, the facility failed to ensure meals were enjoyable and served at palatable temperatures due to use of disposable Styrofoam containers for three sampled residents (R502, R504, and R505) from a total of three sampled residents reviewed for food palatability. Findings include: A complaint received by the State Agency that read that food served by the facility were not palatable. An initial observation was completed on 4/10/25 at approximately 9 AM in the 100 hallway. The observation was made from the main nursing station in the 100 hallway near rooms (150s). A meal cart was parked in the hallway and staff were observed picking up breakfast trays from resident rooms. The breakfast meal was in Styrofoam boxes placed on the tray. The surveyor opened the cart and observed six breakfast trays with a Styrofoam box on every tray. Later that day staff were observed picking up trays from room [ROOM NUMBER], the trays had Styrofoam boxes. R502 R502 was long-term resident of the facility originally admitted to facility on 5/2/22. R502's admitting diagnoses included type 2 diabetes, Chronic Obstructive Pulmonary Disease (COPD), major depressive disorder and heart disease. Based on Minimum Data Set Assessment (MDS) dated [DATE], R502 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition. An initial observation was completed on 4/10/25 at approximately 12:30 PM. R502 was observed laying on their bed. They had a pack of cheese, that appeared soft and had a bag of chips on their bed. They were eating chips and cheese. When queried if they had lunch, they reported they did not like the food that was being served and they were not interested in any alternatives. They added that their family brought them food and snacks. When queried about the food further, they reported that they were vegetarian but ate fish. They were eating facility food on and off until last week and now they preferred to eat the food that their family brought. They added that food served was not hot and was served in Styrofoam containers. The disposable containers did not hold the temperature and food did not taste good. When queried how often they were served in Styrofoam containers, R520 reported that the facility was serving on an average 3-4 times in Styrofoam containers. When queried if there were any specific days or times they reported that it was various days, it was either breakfast or dinner, has been going on for months. They added that facility leadership was aware of this ongoing issue. R504 R504 was also a long-term resident of the facility. They were admitted to the facility on [DATE]. R504's admitting diagnoses included COPD, moderate protein calorie malnutrition, polyneuropathy, and insomnia. Based on MDS assessment dated [DATE], R504 had a BIMS score of 15/15 indicative of intact cognition. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An initial observation was completed on 4/10/25 at approximately 9:25 AM. R504 was in their bed and they were receiving supplemental oxygen therapy via nasal canula. They were queried about their breakfast. They reported that they just had breakfast. They added 'I am not going to lie to you and reported that food was not hot, and did not taste right when it was not hot. When queried further they added that their breakfast was served in a Styrofoam box and it did not hold the temperature. They did not know why they were served in disposable boxes. They were queried if today was an isolated incident and R504 reported that it happened 3-4 times per week and had been ongoing. R505 R505 was also a long-term resident of the facility and they were admitted to the facility on [DATE]. R505's admitting diagnoses included stroke, spinal stenosis (Spinal stenosis is condition in which the spinal canal, the space that surrounds the spinal cord, becomes narrowed. This narrowing can put pressure on the nerves and spinal cord, leading to pain, numbness, weakness, and other symptoms). Based on the MDS assessment dated [DATE], R505 had a BIMS score of 15/15. An initial observation was completed on 4/10/25 at approximately 1:05 PM. R505 was observed in their bed and a lunch tray was on their bedside table. An interview was conducted during the observation. R505 confirmed that they were the Resident Council president. When asked about the food, R505 reported that food served was often not hot and therefore it did not taste right. When queried about the breakfast. They reported that the temperature was worse when they get served in Styrofoam boxes. When queried further about the use of disposable containers, R505 reported that it happened at least 3-4 times per week and it had been ongoing. They added that were not sure why and they thought may be the kitchen did not have enough help. When queried further if they had brought up the concern during the Resident Council meeting, R505 reported that they had brought it up multiple times in their meetings including other residents who attended the meeting regularly. An interview with Dietary Manager (DM) A was completed on 4/10/25 at approximately 2:15 PM. They were queried about the resident's complaints about the food temperature/palatability and serving in Styrofoam containers. DM A reported that they had to serve in Styrofoam containers today for breakfast because two kitchen team members had called off. When queried about the (multiple) resident reported frequencies of 3-4/week, they reported that it was not that often, but they had to use disposables due to their staffing issues. They added that they were in the process of hiring new staff. DM A added that they had staffing challenges and it impacted the serving of breakfast and dinner when they had call offs and they were able to manage for lunch due to their overlapping schedule. They were notified of the resident concerns about food not being served in palatable temperatures when served in Styrofoam containers, they agreed that it was hard to maintain appropriate temperatures and understood the concerns. An interview with Administrator was completed on 4/10/25 at approximately 3:05 PM. They were notified of the observations of Styrofoam containers used for breakfast and concerns from multiple residents about ongoing use of Styrofoam containers (3-4 on an average) and appropriate temperature for food palatability, including the Resident Council president. They were also notified of the interview with DM A. They were notified that per the Resident Council president the resident council had brought the concerns on multiple resident council meetings. No additional explanation was provided. Review of the facility provided document titled Food Temperatures with a revision date of 1/9/25, read in part, Foods will be maintained at proper temperature to ensure food safety. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedures: 1.The temperature of holding hot foods at point of service will be > 135 degrees Fahrenheit 2.The temperature of cold foods at point of service will be <41 degrees Fahrenheit 3.The cook is responsible for ensuring all food is cooked to proper internal temperatures and held at proper serving temperature. 4.Food temperatures will be taken and recorded for TCS (Temperature Controlled Foods) at all meals. Record temperatures on the food temperature record. 5.Test trays will be conducted periodically and food temperatures, as served to the resident will be monitored by the Nutrition Professional .