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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	01/14/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 #'s 2699473, 2699484, and 2699520.Based on interview and record review, the facility failed to notify the Doctor, Nurse Practitioner, or Physician's assistant of an acute change of condition and ensure a timely transfer to the emergency room (ER) for one resident (R202), of two residents reviewed for an acute change of condition, resulting in R202 not being transferred to the emergency room timely, deemed not a candidate for surgical intervention, and ultimately death from sepsis. Findings include:A complaint received by the State Agency alleged the resident was not appropriately treated for an acute change of condition.On [DATE] at 2:15 PM a phone call was conducted with the complainant. They said R202 admitted to the facility on [DATE] in the afternoon. On the evening of [DATE] they said R202 developed, extreme pain in their abdomen with nausea and vomiting. They said they requested an evaluation from a physician on [DATE] during the evening and was told someone would be in on the morning of [DATE]. They further reported on [DATE] R202's pain intensified, their temperature was extremely low, they were diaphoretic (sweating) and their vital signs were unstable. They said R202 was seen by a Physician's Assistant (PA) on [DATE] around 3 PM. They said the PA ordered labs and an abdominal X-ray, and R202 was treated with Zofran (anti-nausea medication) and Tylenol for pain. They continued to say that on [DATE] in the early evening R202 went into respiratory distress saying her respiratory rate was greater than 30 and her labs came back around 6 PM with a critically high white blood cell count (indicative of an infection). They further reported R202 was sent to the emergency room at approximately 7 PM and when they arrived, it was too late. They were asked what was going on with the resident at the hospital and said R202 had something wrong with her colon (they did not know exactly what), they were septic (a life-threatening medical emergency where the body's extreme response to an infection damages its own tissues and organs, potentially leading to organ failure and death) and nothing could be done. They said R202 died on [DATE] and if they would have known, they would have called an ambulance themselves to transfer R202 to the emergency room. The complainant provided R202's death certificate via e-mail for review.On [DATE] at 4:21 PM, a review of R202's death certificate was conducted and the CAUSE OF DEATH section listed, a. Sepsis and b. Pneumatosis Intestine, a condition where gas collects in the wall of the small or large intestine, and is a sign of an underlying issue, ranging from benign to life-threatening, like bowel ischemia or infection.On [DATE] at 9:48 AM, a review of R202's closed clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included: heart failure, edema, chronic kidney disease, atrial fibrillation, high blood pressure, muscle wasting and atrophy. A progress note entered into the record on [DATE] at 12:08 AM indicated R202 was alert and oriented to person, place, and time.A review of R202's vital signs and documented pain scores was conducted and revealed the following:[DATE] at 9:27 AM documented by Nurse 'A', Blood pressure 178/105, heart rate 125 (normal is less than 100) with an irregular rhythm, and temperature 94.8 (normal is 98.6)XXX[DATE] at 10:50 AM, (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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NAME OF PROVIDER OR SUPPLIER Regency at Waterford		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N Telegraph Rd Waterford, MI 48328	

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	pain score documented as [DATE]/25 at 2:38 PM, documented by Nurse 'B', Blood pressure 101/86, heart rate 133 with an irregular rhythm, and temperature 96.6XXX[DATE] at 2:44 PM, pain score documented as 7/10.On [DATE] at 11:40 AM, a telephone interview was conducted with Nurse 'A' and they were asked if they reported R202's abnormal vital signs (high blood pressure, high heart rate, and low temperature) to the Doctor, Nurse Practitioner (NP), or Physician's Assistant (PA). They said, I'm pretty sure I reached out to the NP or PA.A review of R202's clinical record revealed no indication the Doctor, NP, or PA were made aware of the abnormal vital signs on [DATE] at 9:27 AM.Continued review of R202's clinical record revealed a progress note entered into the record by Nurse 'B' on [DATE] at 2:39 PM that read, .Writer assesses resident with daughters at Bed side. PA (PA 'C') present. VS (vital signs) reassessed. Complaint of abdominal pain. Pt has vomited 10cc of green emesis.PA ordered; [sic] Abdominal X-ray for abdominal pain, nausea.It was noted PA 'C' did not include a note in the record regarding their assessment of R202 on [DATE] at approximately 2:40 PM.The last note entered into R202's record by Nurse 'E' on [DATE] at 7:53 PM was reviewed and read, .Writer observed pt (patient) hyperventilating in own room at 1830 (6:30 PM).Writer obtained pt vs (vital signs); 154/78, 120bpm (heart rate), 32resp/min, (respiratory rate). Writer contacts On-Call Prescriber to notify of sepsis like symptoms, as writer is on the phone with On-Call provider, second nurse receives a phone call from (Laboratory Company) with a critically high WBC (white blood cell count) of 31,700 .(Normal WBC 4.0-11.0) Provider is made aware and orders pt to be sent out to ER for sepsis.On [DATE] at 12:05 PM, a telephone interview was conducted with PA 'C' regarding their assessment of R202. They said R202 was, in poor condition when they saw them. They were asked what, poor condition meant and said R202 was flat in bed with a damp towel on her chest. PA 'C' further reported R202 was not actively vomiting but had an emesis basin on the bedside table. They further indicated R202 was complaining of pain to the left upper quadrant of their abdomen. PA 'C' then said they ordered an abdominal X-ray and stat labs. They were asked if they were aware of R202's vitals earlier in the day ([DATE] at 9:27 AM, Blood pressure 178/105, heart rate 125 with an irregular rhythm, and temperature 94.8) and said they had not been made aware, nor did they review R202's previous vital signs. PA 'C' was asked about R202's vitals documented at 2:38 PM on [DATE] and said they suspected sepsis so they ordered the X-ray and the stat labs. PA 'C' was next asked if they considered sending R202 to the emergency room and said they wanted to see what the results of the labs and X-ray were before they sent them. PA 'C' then said later in the evening on [DATE] the labs were reported to them with a critical high white blood cell count so they called the facility to have the resident transferred.On [DATE] at 12:46 PM, an interview was conducted with Dr. 'D', supervising physician for PA 'C'. They were asked if R202's vitals at 9:27 AM on [DATE] should have been reported to either them, a PA, or a NP and said they should have. Dr 'D' was next asked their professional opinion for the variance in the vitals between 9:27 AM on [DATE] and 2:38 PM on [DATE] and said it could be caused by several things including sepsis. They were asked what they would have done had they been contacted and said they may have started fluids and probably would have sent them to the emergency room. At that time, Dr. 'D' was made aware R202 was not sent to the emergency room until approximately 7 PM on the evening of [DATE] to which they replied, That is very concerning. I am disappointed it happened.On [DATE] at 1:25 PM, an interview was conducted with the facility's Director of Nursing (DON). R202's clinical record was reviewed with the DON and they were asked if Nurse 'A' should have contacted a Doctor, NP, or PA regarding R202's vital signs on [DATE] at 9:27 AM and said they should have; agreeing the blood pressure, heart rate, and temperatures recorded on [DATE] were a concern. The DON was then asked why the facility didn't send R202 to the emergency room sooner given their vital signs, pain levels, and (continued on next page)

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