

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER Regency at St Clair Shores		STREET ADDRESS, CITY, STATE, ZIP CODE 22700 Greater Mack Ave Saint Clair Shores, MI 48080	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384</p> <p>This citation pertains to Intakes MI00153087 and MI00153316.</p> <p>Based on observation, interview, and record review the facility failed to prevent incidents of misappropriation of narcotic pain medication for four residents (R901, R902, R903, R904) of four residents reviewed for misappropriation of property. Findings include:</p> <p>A review of a complaint submitted to the State Agency (SA) revealed the following. .The first few nights [R901] was a resident [at] this facility [they] complained about not receiving medication. When I had the phone conference with the social workers. I believe someone in the room indicated that [R901] was given meds at 9pm and again 5am. But doses was [were] missing in between those times .May 14th [R901] called indicating, [they hadn't] received pain medicine since 5 PM the previous day, which was May 13th . The nurse indicated that they have to put in a request for more medication .</p> <p>R901</p> <p>On 5/29/25 at 9:17 AM, R901 was interviewed via phone and explained that following back surgery, they were admitted into the facility with severe pain, which was not resolved to the point that they transferred back out to the hospital. R901 explained when their pain pill was asked for, they were advised by the assigned nurse, additional pain medication had to be ordered.</p> <p>A review of R901's medical record revealed they were admitted into the facility on [DATE] and discharged on [DATE] with diagnoses which included Fusion of Spine, Lumbar Region, Diabetes, and Hyperlipidemia. Further review revealed the resident was cognitively intact and required assistance with transfers and toileting.</p> <p>Further review of R901's medical record revealed the following physician order dated for 5/9/25, Hydrocodone (narcotic pain medication) Acetaminophen Oral Tablet 10-325 MG (milligrams). Give 1 tablet by mouth every 4 hours as needed for pain.</p> <p>Further review of R901's medical record revealed a Controlled Substances Proof of Use form dated for 5/9/25 noting 18 pills were received, and all 18 pills had been administered to the resident prior to discharge 6 days later.</p> <p>Further review of R901's medical record revealed a Medication Administration Record (MAR) for the month of May which documented the resident was administered 16 narcotic pain pills.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R902</p> <p>A review of R902's medical record revealed they were admitted into the facility on [DATE] with diagnoses which included Periprosthetic Fracture around internal prosthetic right hip, Anemia and Dementia. Further review revealed the resident was cognitively impaired and required substantial assistance for bathing and bed mobility. Further review revealed the resident was severely cognitively impaired.</p> <p>Further review of the medical record revealed an active physician order dated for 4/30/25, Order Summary:</p> <p>Oxycodone (narcotic pain medication) HCl Oral Tablet 5 MG. Give 1 tablet by mouth every 4 hours as needed for Pain.</p> <p>A review of the resident's Controlled Drug Receipt/Record/Disposition Form revealed the resident received their narcotic pain pill on the following dates: 5/7/25 (2 doses), 5/8/25 (2 doses), 5/9/25 (3 doses), 5/12/25 (3 doses) and 5/13/25 (3 doses).</p> <p>A review of R902's May MAR revealed the resident did not received one dose of medication on 5/7/25, 5/8/25, 5/9/25, and 5/12/25. On 5/13/25, it was documented that the resident received 2 doses.</p> <p>R904</p> <p>A review of R904's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Metabolic Encephalopathy, Dysphagia, and Type II Diabetes. Further review revealed the resident had a severe cognitive impairment and required maximum assistance with activities of daily living.</p> <p>Further review of the resident's medical record revealed the following physician order dated 5/1/25, Hydrocodone Acetaminophen Oral Tablet 5-325 MG. Give 1 tablet by mouth every 4 hours as needed for Pain.</p> <p>Further review of the resident's medical record revealed a Controlled Drug Receipt/Record/Disposition Form dated 5/2/25 documenting the medication had been dispensed 26 times. Documentation revealed the resident was administered their prescribed narcotic medication 19 times.</p> <p>A review of R904's May MAR revealed the resident received a documented 19 doses of the pain medication, and also revealed discrepancies when compared to the Controlled Drug Receipt/Record/Disposition Form: 5/4/25, 5/7/25, 5/8/25, 5/9/25 (3 doses), and 5/28/25.</p> <p>On 5/29/25 at 11:49 AM, the Director of Nursing (DON) was asked to review R901 and R902's May MARs and Narcotic Sheets together. The DON acknowledged the discrepancies and revealed there was a concern for drug diversion for Nurse A, but have also started to see a concern regarding another nurse who they were going to call into the facility. The DON further explained that a Past Non-Compliance (PNC) had been completed with a correction date of 5/27/25.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the PNC revealed a compliance date of 5/27/25 however, the surveyor reviewed discrepancies dated for 5/28/25 on narcotic sheets, with additional residents appearing to be affected by Nurse A's drug diversion.</p> <p>R903</p> <p>A review of R903's medical record revealed they were admitted into the facility on [DATE], and readmitted [DATE] with diagnoses that included Metabolic Encephalopathy, Dementia, Schizophrenia, and adjustment disorder. Further review revealed the resident had a moderate cognitive impairment and required partial/moderate assistance for bathing and bed mobility.</p> <p>Further review of R903's physician order dated 11/4/24, Tramadol (narcotic pain medication) HCl Oral Tablet 50 MG (Tramadol HCl) Give 2 tablet by mouth at bedtime for Pain.</p> <p>A review of a Facility Reported Incident (FRI) reported to the SA revealed the following, Incident Summary: On 5/19/25 it was reported by morning charge nurse Licensed Practical Nurse [LPN] B there were discrepancies in the narcotic count. [Nurse A] was the midnight nurse in question. [Nurse A] stated that she did not know what happened. [Local Police] notified Administrator paged [Nurse A] and [Nurse A] saw the police and left the facility .</p> <p>On 5/29/25 at 12:52 PM, an interview was completed with the DON who acknowledged there were discrepancies with the narcotic count for R903. The DON explained midnight shift nurse, Nurse A was finishing the shift, and the oncoming nurse, LPN B was starting their shift, and while completing the narcotic count, noticed a discrepancy. Nurse A's behavior was described as odd, and when questioned about the discrepancy, indicated they would assess the resident. Nurse A was suspended per policy and sent to go get a urine and hair drug screen. Nurse A appeared for drug testing a day late and refused the drug screen of their hair. Regarding the PNC the DON acknowledged more work needed to be completed regarding misappropriation.</p> <p>On 5/29/25 at 2:13 PM, an interview was completed with Unit Manager C regarding the missing medication. Unit Manager C explained they had received a call from the morning shift nurse (LPN B) advising the narcotic count was off. Upon arriving to the facility, Unit Manager C observed Nurse A behaving oddly and was located laying in a resident's bed appearing sleep. When Nurse A was woken up, and questioned about the documentation of the narcotic count, which indicated there were 82 pills, and written underneath were the words, actual 80. Unit Manager C explained they questioned Nurse A further about the documentation and stated they abruptly left and indicated they would go assess the resident. Nurse A was called down to the Administrator's office, but instead left the building.</p> <p>On 5/29/25 at 2:36 PM, an attempted phone call was made to Nurse A to no avail, and the surveyor was unable to leave a message.</p> <p>A review of R903's Controlled Drug Receipt/Record/Disposition form dated 5/7/25 revealed that Nurse A crossed out and documented confusing information on the form.</p> <p>A review of the facility's Pain Management policy revealed the following, 14. The staff will implement the care plan, monitor the residents, and administer therapeutic interventions for pain, if ordered. 15. The licensed nurse, when administering routine pain medications, will record the drug administration on the medication administration record.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>16. The licensed nurse, when administering PRN pain medications, will record the drug administration on the PRN medication administration record. 17. Document the date, time, and effectiveness of PRN pain medication on the PRN Administration Record .</p> <p>A review of the facility's Abuse Prohibition policy revealed the following, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property .Misappropriation of guest/resident property means that deliberate misplacement, exploitation, or wrongful, temporary or permanent use of guest's/resident's belongings or money without the guest's/resident's consent .</p>		