STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235319	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at St. Clair Shores	22700 Greater Mack Avenue St. Clair Shores, MI 48080

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respond to call lights in a timely manner for 11 residents (R47, R110, and a confidential group of nine residents) out of 11 residents reviewed for call lights. Findings include: R110 On 8/4/25 at 10:03 AM, R110 revealed “This place is short of help on nights, everyone knows we are short, it doesn't get better, it gets worse, not recently getting showers”. R110 further revealed once they were in bed, no one checked on them all night. R110 further explained when they put on their light, staff would take a long time to come, then turn it off and go out without addressing their needs. R110 reported finally in the morning the staff got them up. On 8/4/25 at 2:15 PM, another resident approached and indicated they were looking for a surveyor. This resident then related that on the weekend, R110, was calling out very early in the morning around 5:45 AM. This went on for quite some time when that resident finally got up to see what the problem was and went into the hall and found a staff member and asked why someone was yelling all night. The staff member first indicated no one was yelling all night. Approximately 5-10 minutes later the same resident was yelling again, The resident recognized where it was coming from and asked the staff if they were going to answer the call, and the staff proceeded into R110's room. A review of resident council meeting notes for the months of March 2025 through July 2025 revealed issues related to Call lights being answered promptly. On 8/5/25 at 1:15 PM, a confidential group meeting was conducted with seven confidential group residents, and they were asked about the timeliness of call light response by facility staff. All group residents present indicated that call light response on the night shift (11:00 PM to 7:00 AM) was slow. The group indicated that at night they needed assistance with receiving snacks, toileting, brief changes, bed repositioning, and other miscellaneous care type needs. The group was asked what the facility had done to address the concerns regarding call light response on the night shift. The group reported that this had been an ongoing concern since March 2025 and had been brought up at each resident council meeting. The group further indicated that although the facility had informed them that they were working on it, nothing had changed. On 8/6/25 at 11:30 AM, Certified Nursing Assistant (CNA) H was interviewed regarding staff coverage at the facility on the night shift. CNA H revealed that they filled in on the night shift as scheduled and indicated there was not enough staff to meet the residents' needs. CNA H indicated there was (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	typically one CNA per unit with thirteen to fifteen residents to care for and the acuity (severity of illness) of the residents at the facility was typically high, and many residents required two-person assistance for transfers which could be problematic on the night shift. On 8/6/25 at 11:35 AM, CNA I was interviewed regarding staff coverage at the facility on the night shift. CNA I revealed that they filled in on the night shift as scheduled and indicated that there was not enough staff scheduled to adequately meet the residents' needs. CNA I expressed feelings of anxiety and stress when assigned to work on a night shift. On 8/6/25 at 11:40 AM, CNA J was interviewed regarding staff coverage at the facility on the night shift and confirmed they filled in on the night shift as scheduled and said they were typically assigned sixteen to seventeen residents to care for on the night shift. CNA J stated, That's too much. On 8/6/25 at 11:46 AM, CNA K was interviewed regarding staff coverage at the facility on the night shift. CNA K revealed they filled in on the night shift as scheduled and said when two staff are needed for resident assistance, it takes away from being able to assist other residents. On 8/6/25 at 1:30 PM, the acting Director of Nursing (DON) was interviewed regarding expectations related to call light response by facility staff. The ADON said the policy was call lights should be answered within twenty minutes. The acting DON was asked about there being five consecutive months of resident council meeting notes (March 2025 to July 2025) which indicated ongoing issues related to call light response times and said they were not aware this was a resident concern. R47 On 8/5/25 at 9:30 AM R47 was observed lying in the bed in room. When queried about care, R47 said there is a long wait to be changed during the evening and the midnight shift. R47 stated they have waited for assistance at times from thirty minutes up to an hour before staff would answer the call light. A review of the medical record revealed R47 was admitted on [DATE] with the diagnoses of Cellulitis, Mild Cognitive Impairment, Chronic Obstructive Pulmonary disease and depressive episodes. A review of the Minimum Data Set assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) of 12/15 which indicates moderate cognitive impairment. Further review of the medical record revealed R47 required extensive assistance from facility staff with their activities of daily living. On 8/6/25 at 12:30 PM, the Nursing Home Administrator (NHA) was asked if they were aware of the residents' concerns regarding long waits with call lights for assistance on the midnight shift and reported they were not aware of the concerns. The NHA confirmed the expectation is, all resident call lights should be answered in a timely manner. On 8/6/25 at 1:00 PM, the Activity Director (AD) was queried about the process of handling the resident council concerns. The AD said resident council concerns are brought to each department head at the interdisciplinary department management team (IDT) meetings which were held each morning and evening. The AD confirmed the department heads were notified of the resident concerns after each meeting. A review of the facility policy titled Call Lights effective 3/12/25 revealed, Call lights will be placed within resident's reach and answered in a timely manner.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat one resident (R24) of one resident reviewed with dignity and respect. Findings include: On 8/05/2025 at 9:30 AM, the surveyor was standing at the Station 1 Unit C nurse's station when R24 stopped and engaged in conversation and asked for two cups of ice from the surveyor. R24 was advised to ask an unidentified staff member, later identified as Licensed Practical Nurse A (LPN A) for assistance as she sat at the nurse's station looking at her phone. On 8/05/2025 at 9:32 AM, R24 was observed wheeling toward LPN A, and politely asked her for two cups of ice. LPN A appeared visibly annoyed by R24's request by barely providing eye contact with the resident and sounded curt and dismissive as she indicated that someone else would be around for them to obtain the request. R24 rolled away from LPN A as they waited for another staff member to appear and assist them.On 8/05/2025 at 9:34 AM, the surveyor approached LPN A and asked her why she didn't assist R24 with their request, and she explained that her shift ended at 7:00am and was supposed to be off work but was documenting two resident falls from last night. No other explanation was provided.A review of R24's medical record revealed they were admitted into the facility on 6/26/25 with diagnoses that included Staphylococcal Arthritis, Left knee, Adult T-Cell Lymphoma/Leukemia, Anemia, and Diabetes. Further review revealed the resident was cognitively intact, and required partial to moderate assistance for transfers, toileting, and personal hygiene.Further review of R24's medical record revealed the following care plan, .Focus: [R24] is at risk for nutritional decline r/t (related to): PMH (past medical history) of uncontrolled DM (diabetes mellitus) with therapeutic diet and IV (intravenous) therapy .Interventions: Encourage and provide intake of fluids throughout the day. Initiated 6/26/2025 .On 8/06/2025 at 12:00 PM, the Nursing Home Administrator (NHA) was asked about their expectation for ensuring residents are treated with dignity and respect and explained that their [NAME] is Customer Service first.On 8/06/2025 at 2:32 PM, the acting Director of Nursing (DON) was informed of the interaction between R24 and LPN A and explained the nurse should have provided the resident with their request. A review of the facility's Resident Rights policy revealed the following, The facility protects and promotes the rights of each resident. The resident has a right to dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop or revise care plans for two residents (R11, and R13) of three residents reviewed for care plans. Findings include:R11On 8/4/25 at 10:47 AM, R11 was observed to have a PEG (Percutaneous Endoscopic Gastrostomy [feeding tube]), visible under their t-shirt. R11 indicated it was currently not being used. A review of the Electronic Medical Record (EMR) revealed R11 was admitted to the facility on [DATE] with the following relevant diagnoses: Myasthenia Gravis (autoimmune disorder causing weakness in voluntary muscles, affecting communication between nerves and muscles), Moderate Protein Calorie Malnutrition, Renal Dialysis, Dysphagia (difficulty swallowing), and Gastrostomy Insertion (PEG tube). Further record review revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. R11 required supervision/touching assistance for Activities of Daily Living (ADLs). R11 was independent with mobility using a walker.Further review of the EMR care plans revealed there was not a care plan addressing the care and interventions for the PEG tube.R13On 8/4/25 at 9:03 AM, R13 was observed in bed, verbally requesting to get up. R13 was asked about their urinary elimination, they patted to their abdomen where nephrostomy tubes were noted.A review of the Electronic Medical record (EMR) revealed R13 was admitted to the facility initially on 11/30/21 and readmitted on the following dates: 2/17/25, 4/7/25, 5/20/25, 7/3/25 and 7/8/25, with the following relevant diagnoses: Multiple Sclerosis, Obstructive and Reflux Uropathy, Neuromuscular Dysfunction of Bladder, and Artificial Opening of Urinary Tract (Nephrostomy Tube-a tube placed inside the kidney and connected to a drainage device located on R13's back) and urinary diversion (a urostomy connected to a drainage bag on R13's abdomen). R13 required substantial/maximal assistance for all activities of daily living and mobility.Further review of the EMR documentation revealed a progress note on 2/15/25, R13 was transferred to the hospital for a nephrostomy tube that was dislodged by Licensed Practical Nurse (LPN) M. A 72-hour admission Conference form dated 2/19/25 documented, (Name of resident) remains for LTC (long term care) .Baseline care plans left at bedside. The care plan was not noted to be updated with interventions to prevent dislodgement after this readmission.Review of the documentation revealed on 4/6/25, R13 was again transferred to the hospital for nephrostomy bag was not attached to the resident by LPN N. The care plan was not noted to be updated with interventions to prevent dislodgement after this readmission.Review of the documentation revealed on 5/16/25, R13 was again transferred to the hospital for nephrostomy tube replacement by LPN O. A 72-hour admission Conference form revealed, admitted following hospitalization for nephrostomy replacement. The care plan was not noted to be updated with interventions to prevent dislodgement after this readmission.Further review of the documentation by LPN N revealed on 7/1/25, R13 was complaining about pain in arm. R13's husband transported them to hospital. Nurse Practitioner (NP) P received notification, pt has disconnected their nephrostomy tube . readmitted [DATE] following hospitalization for nephrostomy replacement.Baseline care plans left at bedside. The care plan was not noted to be updated with interventions to prevent dislodgement after this readmission.On 8/5/25 at 1:00 PM, Registered Nurse (RN) B indicated care plan updates are done by the Minimum Data Set (MDS) nurse and Social Work.On 8/6/25 at 10:40 AM, SW E revealed the issue was not necessarily behavior because it was related to a medical device and should be addressed by nursing. On 8/6/25 at 1:43 PM, Attending Physician (AP) F revealed they were aware of frequent issues with R13's nephrostomy tube.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide psychotropic medications in a timely manner for one resident (R80) of one reviewed for pharmacy services. Findings include: On 8/04/2025 at 2:10 PM, R80 was observed in their room and asked about their time spent in the facility. R80 explained they are prescribed a lot of medications, and their guardian had expressed concerns about them not obtaining a shot when they were supposed to.A review of R80's medical record revealed they were admitted into the facility on 4/11/25 with diagnoses that included Schizoaffective Disorder, Anxiety Disorder, and Other Recurrent Depressive Disorders. Further review revealed the resident was cognitively intact and required supervision for activities of daily living (ADL's).Further review of R80's medical record revealed the following: Abilify Maintena (extended-release psychotropic injection is used to treat Schizophrenia and Bi-Polar Disorder) Intramuscular Prefilled Syringe 400 MG (milligrams) Inject 400 mg intramuscularly one time a day starting on the 19th and ending on the 19th every month for Bipolar Disorder-Start Date: 05/19/2025. This order was discontinued on 6/16/25.Further review revealed an active physician's order dated 6/16/25, Abilify Maintena injection Intramuscular Prefilled Syringe 400 MG (Aripiprazole) Inject 400 mg intramuscularly one time a day starting on the 2nd and ending on the 2nd every month for Bipolar Disorder.A review of R80's May 2025 and August 2025 Medication Administration Record (MAR) revealed the resident did not receive their injectable medication as ordered. Further review of the medical record revealed the following progress notes:7/19/2025 07:47 (7:47am) Social Services Note: During care conf (conference) yesterday, sister/LG (legal guardian) indicated R80 told her [they are] having auditory hallucinations of a sexual nature, which did not cause [them] distress. Psych to re-eval at next visit.Date of Service: 2025-07-21 08:15:00. Chief Complaint. Psychiatric follow up, medication review, hx (history) schizophrenia. History of Present Illness.today for follow up to review medication and to assess mood. Patient was last seen for psychiatry on May 20, 2025 at which time no psychotropic changes were made. Patient does have an extensive history of paranoid schizophrenia, anxiety, depression, and history of psychoactive substance abuse. At last visit in May, [R80] was not receiving [their] Abilify Maintena long acting injectable correctly and since then has had the dosing changed to be given on the second of every month. [R80] continues to remain on Abilify Maintena intramuscular syringe 400 mg (milligrams)/2 ML (milliliters) 2 ML IM on the second of the month once a month. [R80] received this injection on June 2 and July 2 but did not get the injection in May per documentation Assessment and Plan .Paranoid schizophrenia: Patient has been on a long-standing psychotropic regimen that includes Abilify 5mg oral daily, Abilify Maintena 400mg IM monthly, Haldol 10mg at bedtime, and benztropine 2mg twice daily. There were recent concerns about patient having sexually inappropriate auditory hallucinations, which were reported by [their] sister. Patient was not receiving his Abilify Maintena consistently and did not receive it in the month of May, but did receive it consistently in June and July. Sometimes it can take up to 2-3 months of receiving the injectable consistently to fully cover psychosis .7/24/2025 13:22 (1:22pm). Resident At Risk, Reviewed Clinical Indicator: Auditory hallucinations of a sexual nature. Verbalizing a desire to discharge, not verbalized previously .Psych eval. (evaluation) Reminded nursing to watch [R80 take their] medications. Looking for a ltc (long-term care) facility to accommodate [R80] long term. Previous referrals unsuccessful .No med changes at this time, likely needs to continue with antipsychotic injection consistently.On 8/06/2025 at 9:04 AM, R80's assigned nurse, Licensed Practical Nurse (LPN) G was asked why R80 had not received their Abilify injection, and explained she did not know why however, there was a new order for the medication Invega placed today. A review of R80's physician's orders dated 8/6/25, Invega Sustenna (an extended-release antipsychotic medicine given by injection).156 mg/1mL IM Q30 (every 30 days) days along with oral Invega 3 mg daily.Further review revealed the following progress note:8/5/2025 08:00BH -Psychiatry Follow up (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.seen today for follow up to review medication and to assess mood at the request of social services and patient's sister due to concerns of an increase in psychotic symptoms. Patient has an extensive history of paranoid schizophrenia, anxiety, previous mood disturbance, and history of psychoactive substance abuse. [R80] is on Abilify Maintena long acting injectable 400 mg IM on the second of each month, but did not receive the injection on August 2 as the building did not have the injection available .[R80's] sister has concerns even prior to the injection being missed about the control of his psychosis with the use of Abilify. She informed social services that roughly around 4 to 5 months ago, [R80] was on Invega Sustenna long acting injectable one time monthly and that was better for coverage of [their] psychosis, but that the medication was causing gynecomastia (enlargement of breast tissue in men and boys), and therefore]R80] had been switched to Abilify long-acting injectable On 8/06/2025 at 12:00 PM, a telephone Interview was completed with R80's guardian in which they expressed concern regarding the resident not obtaining their injection due to the pharmacy not providing the medication to the facility. On 8/06/2025 at 1:24 PM, the acting Director of Nursing (DON) explained they had spoken to the resident's assigned nurse on 8/2/25, and she explained that upon opening the medication to administer to R80, she noticed the medication appear to have a white substance in it and therefore discarded it and reordered it from the pharmacy. The DON explained the medication was delivered yesterday however, the resident's order had been discontinued.On 8/06/2025 at 1:41 PM, LPN L was interviewed via phone regarding R80's injection, and she explained that upon preparing R80's injection, she noticed the syringe had white stuff in it and discarded it. She further explained she reordered the medication through the pharmacy, ordering it STAT (immediately). LPN L explained she notified the oncoming nurse of the issue and upon arriving for her shift the following day, the medication had not arrived therefore, she contacted the pharmacy again who reported they didn't have the medication in stock and had to deliver it within the next two days. On 8/06/2025 at 2:32 PM, the acting DON was asked about issues the facility has been having with pharmacy and acknowledged they have been working through some challenges however the expectation is residents receive their medication per physician's order. The DON was not sure what occurred in May when R80 did not receive their injection. A review of the facility's Medication Ordering and Receipt policy revealed the following, .3. If the unavailable medication does not become available within 8 hours of the scheduled administration time, the facility will be notified by the pharmacy and an alternate procurement method will be established (i.e. obtaining partial fill from a local pharmacy) .