

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER Regency, A Villa Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12575 S Telegraph Rd Taylor, MI 48180	
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>This citation pertains to intake 1316302. Based on interview and record review the facility failed to prevent the misappropriation of resident's property for one (R702) of seven residents reviewed for abuse resulting in R702 missing 28 doses of hydrocodone (narcotic pain medication). Findings include: The State Agency received a Facility Reported Incident (FRI) on 5/20/25 that identified the misappropriation of a resident's (R702) pain medication by Licensed Practical Nurse (LPN) I. The medication was a schedule II drug; a substance that is classified as having a high potential for abuse and severe psychological or physical dependence. On 7/28/25 at 1:00 PM R702 was interviewed and said that they had received all their pain medications and had no complaints regarding medication administration. On 7/29/25 at approximately 9:30 AM the Director of Nursing (DON) reviewed the FRI investigation report and confirmed that R702's pain medication had been taken by LPN I. The DON stated, On May 6th a nurse went to give the pain med to the resident and saw the cartridge for that medication was empty. She attempted to reorder it from the pharmacy and was alerted that it was not time for refill. We reviewed the narcotic count and realized that 28 pills of the resident's pain meds were missing and unaccounted for. It was easy to determine when the pills were taken. During my discussion with the nurse (LPN I) they refused to come in for an interview. They said they knew they had a problem. The DON said all the nurses had been given an education on the procedure for narcotic reconciliation. Further review revealed the following: the DON could not produce any documentation to indicate there was compliance after the incident was identified, and education had been given. There was no evidence that Agency nurses had received the education. The DON reported, No, there are no audits or follow-up to determine or confirm the nurses are following the narcotic reconciliation procedure. There is no education for the agency nurses. On 7/29/25 at 9:55 AM LPN I was left a voice message on the last known contact information provided by the facility. LPN I has not been available for interview by end of the survey. According to the facility's policy for Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property effective 11/28/2017 in part read, It is the policy of facility that each resident will be free from 'Abuse'.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235333
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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 2565437. Based on interview and record review the facility failed to report a potential incident of neglect for one (R707) of seven resident reviewed for abuse/neglect. Findings include: The State Agency (SA) received an anonymous complaint that a resident had eloped from the facility unbeknownst to facility staff on 7/15/25. On 7/28/25 at 11:30 AM the Nursing Home Administrator (NHA) was asked if any resident had eloped from the facility. The NHA said, Yes, we had a resident that was new to us. The first time he went out to the patio enclosure during an activity he climbed over the fence. We notified the family and the police. At that time the resident's son told us that the resident had eloped from the hospital two times in the past. The resident was found shopping at Kohl's without any injury and is currently with living with his son. The NHA provided an investigation report that confirmed the police, and family had been notified of the missing resident but there was no incident report to the SA. The NHA was asked why the facility did not report the incident to the SA and replied, It got away from us. When the resident was found shopping at Kohl's and safe with the son. I finished the investigation and didn't report it. A review of R707's Electronic Health Record revealed the resident admitted to the facility on [DATE] with multiple diagnoses that included one sided weakness (hemiplegia) and cerebral infarction (stroke). The 5-day Minimum Data Set was incomplete due to R707 not remaining in the facility for the 5 days. A review of the facility's Investigation Report for the incident revealed the police and family had been notified, but not the SA. According to the facility's policy for Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property effective 11/28/2017 in part reads; Neglect is the failure of the facility to provide goods and services to a resident that are necessary to avoid physical harm. G. Reporting and Response. It is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to 2574104. Based on interview and record review, the facility failed to ensure adequate supervision to prevent a resident to resident altercation for one resident (R712) of seven residents reviewed for abuse, resulting in R712 being struck on the head by R711 and the potential for continued physical abuse to occur. Findings include:A review of the facility's investigation summary of a resident-to-resident incident between R711 and R712 documented in part the following: On 7/5/25, at approximately 6:30 PM, there was a verbal exchange between R712 and R711 resulting in R711 ambulating across the room and initiating physical contact with R712. Residents were immediately separated with licensed nurses performing skin, pain, and psychosocial assessments. No injuries noted. Witness statement from Certified Nurse Assistant (CNA) O, dated 7/5/25, I (CNA O) was assisting (unnamed resident) and while walking past the dining room I witnessed (R711) standing over (R712) punching him. I immediately stopped the altercation and called out for assistance. Witness statement from Licensed Practical Nurse (LPN) N, dated 7/5/25, I (LPN N) was in the med room doing paperwork for shift change and (CNA O) came and got me to tell me that (R711) and (R712) were fighting in the dining area. I did not witness the fight. On 7/29/25 at 10:50 AM, Unit Manager/LPN (UM/LPN) F said she was the Unit Manager for the memory care unit where R711 and R712 reside. UM/LPN F said staff must keep certain residents away from other residents to avoid conflict, and this included R711 and R712. When residents are in the dining room, even during non-mealtimes, there should be a staff present to watch what the residents are doing. On 7/5/25 after dinner, around 6:30 PM, there was no staff present supervising the residents in the dining room. A review of the clinical record for R711 documented an admission date of 10/25/24 with diagnoses that included anxiety disorder and vascular dementia. A Minimum Data Set (MDS) assessment dated [DATE] documented severe cognitive impairment. Review of R711's care plans documented in part the following:- Focus: The resident has Vascular dementia with psychotic disturbance, unspecified dementia, unspecified severity with agitation. Date Initiated: 10/31/2024. Interventions: Anticipate and meet needs. Monitor effectiveness of communication strategies and assistive devices. Date Initiated: 11/25/2024- Focus: (R711) has Vascular dementia with psychotic disturbance, unspecified dementia, unspecified severity with agitation. Date Initiated: 10/31/2024- Focus: (R711) has a mood problem related to dementia. Date Initiated: 11/25/2024. Interventions: -Communication: Provide a calm and safe environment to allow resident to express feelings as needed. Provide resident with area for decreased stimulation as needed. Date Initiated: 2/11/2025 A review of the clinical record for R712 documented an initial admission date of 12/14/20 and readmission date of 6/2/25. R712 diagnoses included schizoaffective disorder-bipolar type, schizoaffective disorder-depressive type, antisocial personality disorder, unspecified mood disorder, and anxiety disorder. A MDS assessment dated [DATE] documented severe cognitive impairment. Review of R712's care plans documented in part the following:Focus: (R712) does at times become physically aggressive and bangs on tables or his chair when residents are close to him during activities. (R712) does have difficulty communicating, prefers to use gestures. Dated 10/12/23. Focus: The resident is/has potential to be physically aggressive related to Dementia. Date Initiated: 04/20/2024.Focus: The resident has a psychosocial wellbeing problem (potential) related to resident-to-resident altercation. Date Initiated: 09/07/2021. On 7/29/25 at 12:00 PM, Nursing Home Administrator (NHA) and Director of Nursing (DON) were interviewed regarding the incident between R711 and R712. The NHA reported a video of the incident was reviewed by herself and the DON. The NHA stated the information included in the facility's investigation summary was gleaned from the video of the incident. The NHA indicated the video tape was no longer available for review. The DON recalled the following from reviewing the video: R711 was sitting on a bench leading to the hallway and R712 was sitting at a table. R711 was looking in the direction of R712. R712 put his hand up. The DON noted there was no audio available, but R712 has a history of being verbally aggressive. R711 then stood up and walked over to where R712 was sitting. R711 was observed standing over R712. R711 was observed using his hands and making contact with R712's head. The DON added that staff were not in the dining room when the physical altercation occurred. The DON stated staff should be present in the dining room when residents are in the dining room to provide supervision and make sure things are okay. A review of the facility policy titled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 11/28/17, documented in part the following - Resident will be protected from abuse while they are residing at the</p>		