STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235333	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency, A Villa Center	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop, implement, or document an effective discharge plan of care for one (R222) of five residents reviewed for discharge planning resulting in the delay of home care services and potential delay for follow-up appointments for R222.Findings include: The State Agency received a complaint from R222 that they were not provided with sufficient information at the time of discharge regarding home health care services or follow-up appointments. On 1/14/26 at 1:08 PM R222 said, [NAME] set up home care for me when I left. It took a week after I was home before I could get ahold of anyone. The paper they gave me didn't have any phone numbers on it. I had to call the Social Worker several times before anyone could give me the right number for home care. R222 reported they were living in their home, followed up with their physician, and was receiving home care at this time. According to R222's electronic health record (EHR) the resident admitted to the facility on [DATE] with several diagnoses that included surgical repair of a fractured left femur after a fall at home, anxiety, and left eye blindness. R222 was discharged to their home on [DATE].A review of R222's care plans revealed there was no plan of care for discharge or post-discharge. There was no discharge summary.Progress notes from 9/17/25 - 10/23/25 were reviewed and did not reveal any discharge planning.On 9/17/25 a Social Work (SW) note documented the resident's discharge plan is to return to home. The next SW note dated 10/20/25 reads; Resident received a NOMNC (Notice of Medicare Non-Coverage) with LCD (Local Coverage of Determination) of 10/22/5. He will discharge home with HHC (Home Health Care).The final SW dated 10/23/25 documented the following: The resident was discharged to their home without DME (durable medical equipment) because they already have it at their home.R222's My Transition Home-Discharge form dated 10/22/25 at 3:42 PM was significantly incomplete. There was no phone number for the Home Health Care Agency. There was no information regarding the resident's follow-up appointments. The sections for; Contact information, Medication information, Nursing instructions, Dietary, and Discharge instructions were blank. On 1/15/26 at approximately 10:00 AM the Director of Social Services (SW) G reviewed R222's EHR and could not provide any documentation to support R222 had a discharge care plan or discharge planning. SW G acknowledged R222's 'Transition Home form was incomplete and did not include the HHC agency's phone number or any information regarding the resident's follow-up appointment. SW G said, The Home Health Care agency did not show up to the resident's home until 10/29/25 because they kept missing the calls. It was a week after the resident discharged and he called here because home care hadn't shown up. We called the (HHC) agency to work it out. I was told the resident had missed their (the HHC agency) calls and did not call them back. On 1/15/26 at approximately 11:00 AM the Director of Nursing (DON) reviewed R222's EHR and said, The transition form is incomplete. The Home Care agency was called by us and suppose to call the resident to set up visits, but the resident kept missing the agency's call. The resident did get their medications faxed to the pharmacy of their choice. I don't know (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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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why that information is not documented on the form or in medical record. The DON acknowledged the resident had no discharge care plan or discharge summary. A request for the facility's Discharge policy was requested. According to the facility's Transfer and Discharge Guideline last revised on 5/5/2025 in part reads; Discharge Planning ProcessResidents will be evaluated for their discharge goals, preferences, and care needs to meet their goals. The evaluation information will be used to develop a comprehensive discharge care plan. * The resident will be re-evaluated periodically to identify changes, and the discharge care plan will be modified to reflect any changes. The care plan will be developed by the interdisciplinary team, including the resident's physician, a registered nurse, other staff or professionals in disciplines determined by the resident's needs or requested by the resident, a member of the nutrition services staff and to the extent practicable, the resident and their representative. The resident will be periodically reassessed to identify changes that require modification of the discharge plans and update the plans as needed The resident and representative will be provided with the final discharge care plan.A. Assessments and Discharge [NAME]. Upon admission to the facility and on an ongoing basis, resident will be evaluated based upon a comprehensive assessment and a person-centered discharge care plan will be initiated to address:i. Resident desires and choices1. Goals2. Treatment preferences3. Preference and feasibility for dischargei. Resident representative involvementii. Teaching with resident/resident representative and caregiver support needsiii. Medical condition/diagnoses1. Signs and symptoms2. When to notify a physician3. Laboratory/radiology testing and result explanationi. Medications and Treatments1. Reason for medications2. Common side effects3. Dose, time of day, duration, route4. Evidence of understanding/return demonstrationi. Functional and cognitive statuses and needs1. Resident specific ADLs2. Evidence of understanding/return demonstrationi. Advance Directivesii. Supplies and durable medical equipment (DME)iii. Follow-up appointments (including transportation)iv. Support Services for care following dischargev. Post discharge location (if known)vi. Risk factors for preventable re-hospitalization.C. Discharge .c. Update the resident's comprehensive care plan and discharge plan (if applicable) with any information received form referrals to local contact agencies or other appropriate entities.D. Documentationa. The resident needs and discharge plan must be documented in the medical record. If a discharge to the community is determined to not be feasible, document who made the determination and reason.b. The resident and resident representative will be informed of the final discharge plan. Proper Notice of Discharge will be provided according to the above guidance.c. An evaluation of the resident's discharge needs will be documented in the resident record on a timely basis. The results of this evaluation will be discussed with the resident or resident representative.d. Relevant resident information will be incorporated into the discharge plan to facilitate implementation and avoid unnecessary delays in resident discharge or transfer.e. The Discharge Care Plan as part of the comprehensive care plan and correlating documentation will be maintained in the medical record.D. Discharge SummaryA discharge summary will be completed upon discharge to include:a. Participation with the resident/resident representativeb. How facility will assist resident adjustment to new living environmentc. Details of where resident will resided. Post discharge follow-up detailse. Post discharge medical and non-medical servicesf. Information regarding how the location meets the resident's needs, provides needed support and resources, and meets the resident's preferencesg. A recapitulation of the residents stay in the facility (diagnoses, course of illness/treatment, therapy, lab, radiology and consultation reports)h. A recapitulation of resident's status.i. A reconciliation of resident's pre-discharge meds with post discharge meds

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a discharge summary that included a recapitulation of stay for two (R12, R222) of five residents reviewed for discharge planning.Findings include:Resident 12 (R12): On 1/13/2026 at 11:29 AM R12 was seated in a wheelchair in the hallway and reported they were being discharged today. The resident said, I'm going to stay with my daughter for a little while. R12 was able to self-propel in her wheelchair independently. A review of the R12's Electronic Health Record (EHR) indicated the resident admitted on [DATE] with diagnoses that included cerebral infarction (stroke) affecting the dominate side and a fractured left humerus from a fall at home.R12's Recapitulation of Stay (Discharge Summary) form dated 1/13/2026 at 5:53 PM was incomplete. The Summary of Stay sections 1a-8 were blank. This included information for continuing care and/or special instructions or precautions for continuing care. The Additional Information section was also blank. This included contact information. Resident 222 (R222):On 1/14/26 at 1:08 PM R222 said, [NAME] set up home care for me when I left. It took a week after I was home before I could get ahold of anyone. The paper they gave me didn't have any phone numbers on it. I had to call the Social Worker several times before anyone could give me the right number for home care. R222 reported they were living in their home, followed up with their physician, and was receiving home care at this time. According to R222's electronic health record (EHR) the resident admitted to the facility on [DATE] with several diagnoses that included surgical repair of a fractured left femur after a fall at home, anxiety, and left eye blindness. R222 was discharged to their home on [DATE].There was no Recapitulation of Stay (Discharge Summary) form or discharge summary.R222's My Transition Home-Discharge form dated 10/22/25 at 3:42 PM was significantly incomplete. There was no phone number for the Home Health Care Agency. There was no information regarding the resident's follow-up appointments. The sections for; Contact information, Medication information, Nursing instructions, Dietary, and Discharge instructions were blank. On 1/15/26 at approximately 10:00 AM the Director of Social Services (SW) G reviewed R222's EHR and could not provide any documentation to support R222 had Recapitulation of Stay (Discharge Summary) form completed. On 1/15/26 at approximately 11:00 AM the Director of Nursing (DON) reviewed R222's EHR and said, There is no Recapitulation of Stay (Discharge Summary) form. The DON acknowledged the resident had no Recapitulation of Stay (Discharge Summary) form, discharge care plan or discharge summary. A request for the facility's Discharge policy was requested. According to the facility's Transfer and Discharge Guideline last revised on 5/5/2025 in part reads; Discharge Planning ProcessResidents will be evaluated for their discharge goals, preferences, and care needs to meet their goals.D. Discharge SummaryA discharge summary will be completed upon discharge to include g. A recapitulation of the residents stay in the facility (diagnoses, course of illness/treatment, therapy, lab, radiology and consultation reports)h. A recapitulation of resident's status.i. A reconciliation of resident's pre-discharge meds with post discharge medications.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2711513.Based on interview and record review the facility failed to ensure correspondence between the facility and the dialysis center was implemented for one (R73) of one resident reviewed for dialysis resulting in missed communication for continuity in care. Findings include:On 1/14/26 at 11:59 a.m. R73 was observed on the unit, in a wheelchair at the nurse's station. R73 was observed to be anxious and restless. R73 was shouting (at no one in particular). Staff attempted to redirect R73's behavior by attending to needs however R73 became more agitated and would not communicate what was needed. Staff were observed transporting R73 away from the nurse's station. While in the bedroom, R73 continued to display agitation but would not say what the cause was. On 1/16/26 at 8:10 a.m. R73 was observed by the facility's entrance door (preparing to go to dialysis), as very angry and anxious. The Director of Nursing said R73 was upset to put on shoes and go to dialysis. A complaint was submitted to the State Agency reported by the dialysis center that R73 often arrives at dialysis very angry and anxious. It takes the dialysis staff a while (up to 40 minutes) to calm R73 down to administer the dialysis treatment. The dialysis staff have reported the behaviors to the facility multiple times and requested the facility to administer medications prior to R73 arriving to dialysis. The complaint noted RN I as the facility staff that was contacted about the R73's behavior while at dialysis. On 1/15/26 at 3:34 p.m. RN I was interviewed and said the antianxiety medication was not at the facility on 1/7/26 for R73 to take prior to going to dialysis. The medication could not be ordered in time and arrive at the facility before R73 went to dialysis. Although there was a physician order, a script was needed to order the medication through pharmacy or retrieve from the backup box. RN I was queried about the communication between the facility and the dialysis center. RN I said the telephone communication was not documented because the medication was ordered immediately. Review of the clinical record documented R73 was initially admitted into the facility on 3/3/25 and readmitted on [DATE] with diagnoses that included end stage renal disease, dysphagia, dementia, psychotic disturbance, mood disturbance, and anxiety, and schizophrenia. According to the significant change Minimum Data Set assessment dated [DATE], R73 had severe cognitive impairment (BIMS-6), unclear speech, and required one-two person assistance with most daily activities. R73 go to dialysis on Monday, Wednesday, and Friday with a chair time at 9am and pick up from the facility at 8am. Review of the Dialysis care plan dated 6/9/24 did not document person-centered goals or interventions to adequately address R73's dialysis needs. Review of the nurse's progress notes for 1/7/26 did not document the communication between the dialysis center and the facility. Review of the dialysis communication forms for the month of December and January documented the following in part:12/21/25- Completed by dialysis unit. Complications during visit: Agitation.1/2/26- Completed by dialysis unit. Complications during visit: Agitation.The communications for 1/5 (Monday), 1/7 (Wednesday), 1/9 (Friday) were not in the electronic medical record. On 1/16/25 at 8:33 a.m. the dialysis communication for the dates of 1/5, 1/7, and 1/9 were requested by the Director of Nursing (DON). The DON said they were not readily accessible and had to be found. The DON said documentation is an area that needs to be improved. On 1/16/26 at 11:23 a.m. the dialysis communication forms requested did not include the dates for 1/5, 1/7, and 1/9. On 1/21/26 at 9:21 a.m. the Dialysis Center Administrator N and the Dialysis RN O was interviewed via telephone and said the center is always calling the facility with concerns with R73 such receiving medications prior to arriving to dialysis or behavior. RN O said on 1/7/25 a call was placed to the facility regarding R73's behaviors. R73 was very agitated and angry. R73's behavior was distressing to both the resident and other patients in the clinic. R73 had been exhibiting behaviors (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the last three weeks and the facility was notified both in writing using the communication form and telephone. The dialysis center does not keep copies of the communication forms sent back to the facility. Review of the facility's policy titled Clinical Guideline: Dialysis dated 1/2007 documented in part the following: .Residents receiving hemodialysis are transported routinely out of the facility. Communication is essential for continuity of care. Communication between outpatient dialysis provider and facility should include Written communication form with review of daily weights, any changes in condition or mood. Be cognizant of medications ordered and timing of administration. Review Communication Folder for any pertinent information.