STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235422	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Chene	2295 E Vernor Highway Detroit, MI 48207

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI00150096. Based on observation, interview and record review the facility failed to follow the standard of practice for medication administration for one (R101 of four residents reviewed for medication administration. Findings include: The State Agency received a complaint that R101 did not receive medications on 2/6/25 during the evening medication pass. On 3/25/25 at 10:00 AM R101 was observed in their room, seated in bed watching TV. R101 was interviewed regarding the complaint of missing medications. R101 was observed to open up a notebook and said, Yes, on February 6th I didn't get any of my medications that night. I was worried because I was supposed to get insulin and a blood pressure pill at that time. I didn't say anything to the nurse. The next morning the day shift nurse took my blood pressure and checked my blood sugar. Everything was OK, but it still bothers me that I didn't get my medications that night. R101 did not know who the nurse was on the afternoon/night shift of 2/6/25. According to the resident's Electronic Health Records (EHR), R101 admitted to the facility on [DATE] with multiple diagnoses that included Hypertension (high blood pressure) Heart Disease and Diabetes. The Minimum Data Set (MDS) dated [DATE] indicated the resident had no cognitive impairment and required staff assistance for all Activities of Daily Living. There were no progress notes for 2/6/25. There were no vitals signs or blood sugar results documented on the 2/6/25 PM shift. Review of R101's Medication Administration Record (MAR) revealed the following medications scheduled for 2/6/25 at the 9:00 PM administration time were not signed out: 1) Ascorbic Acid oral tablet (Vitamin C) 1 tablet 2) Atorvastin 40 milligram (mg) 1 tablet 3) Biotene Dry Mouth, mouth wash 30 milliliters (ml) 4) Toujeo SoloStar Pen-injector 34 units of glargine insulin (long-acting) sub-cutaneous injection (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) Artificial Tears, eye drops 1 drop each eye 6) Docusate Sodium 100 mg 1 capsule 7) Furosemide 40 mg 1 tablet 8) Keppra 500 mg 1 tablet 9) Metoprolol Tartrate 25 mg 1 tablet 10) Metoprolol Tartrate 50 mg 1 tablet 11) Clonidine 0.1 mg 1 tablet 12) Gabapentin 300 mg 1 tablet 13) Hydralazine 100 mg 1 tablet Further review of R101's MAR for February revealed the resident's vitals signs were taken on 2/7/25 at 7:00 AM and were within normal limits. The resident's blood sugar result for 2/7/25 at 7:00 AM was 163 and did not require any additional insulin coverage. The MAR for February and March revealed that all vital signs and blood sugar checks had been documented on the MAR along with medication administrations except for the 2/6/25 9:00 PM time. On 3/25/25 at 2:50 PM, Licensed Practical Nurse (LPN) land unit manager reviewed R101's EHR and confirmed that none of the medications for R101 on 2/6/25 during the PM shift had been signed out. LPN I could not explain why the MAR was blank for those administrations. LPN I reviewed the EHR and could not determine who the nurse was assigned to the resident (R101) during the 2/6/25 PM shift. On 3/25/25 at 3:30 PM the Director of Nursing (DON) reviewed R101's EHR and could not provide an explanation why the MAR was blank for all the medications scheduled for administration on 2/6/25 during the PM shift. The DON could not determine who the nurse was assigned to R101 during that time. On 3/26/25 at 9:30 AM the DON said that after going through the electronic scheduling it was determined that LPN J was the nurse assigned to R101 on 2/6/25 during the PM shift. On 3/26/25 at 9:40 AM LPN J was interviewed via phone. LPN J said, I don't know what assignment I worked that night (2/6/25). I don't recall that far back. I have never cared for that resident (R101) and usually don't work that unit. LPN J was asked about the medication administration process and replied. I always sign out my medications after I give them. If the MAR is blank, I didn't give the meds. According to the facility's Medication Administration policy, last revised on 11/2021 read in part: Physician's Orders - Medications are administered in accordance with written orders of the attending physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DOCUMENTATION Record the dose, route, and time of medication on the Medication/Treatment Administration Record. Document if the guest/resident refused

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI00150096. Based on observation, interview, and record review, the facility failed to have complete and accurate medical records for one (R101) of four residents reviewed for medication administration resulting in the medication administration record (MAR) left blank and the inability to determine what nurse was assigned to the resident according to the MAR. Findings include: The State Agency received a complaint that R101 did not receive medications on 2/6/25 during the evening medication pass. On 3/25/25 at 10:00 AM R101 was observed in their room, seated in bed watching TV. R101 was interviewed regarding the complaint of missing medications. The resident opened up a notebook and said, Yes, on February 6th I didn't get any of my medications that night. I didn't say anything to the nurse. R101 did not know who the nurse was on the afternoon/night shift of 2/6/25. According to the resident's Electronic Health Records (EHR), R101 admitted to the facility on [DATE] with multiple diagnoses that included Hypertension (high blood pressure) Heart Disease and Diabetes. The Minimum Data Set (MDS) dated [DATE] indicated the resident had no cognitive impairment and required staff assistance for all Activities of Daily Living. There were no progress notes for 2/6/25. There were no vitals signs or blood sugar results documented on the 2/6/25 PM shift. Review of R101's Medication Administration Record (MAR) revealed there were 13 medications scheduled for 2/6/25 at the 9:00 PM administration time that were not signed out. There was no documentation by any nursing staff on the 2/6/25 PM shift for R101. On 3/25/25 at 2:50 PM, Licensed Practical Nurse (LPN) Iand nurse manager reviewed R101's EHR and confirmed that none of the medications for R101 on 2/6/25 during the PM shift had been signed out, were left blank, and there were no progress notes. LPN I could not determine who the nurse was assigned to the resident (R101) during the 2/6/25 PM shift. On 3/25/25 at 3:30 PM the Director of Nursing (DON) reviewed R101's EHR and could not determine who the nurse was assigned to R101 on 2/6/25 during the evening shift. The DON said the facility used an electronic scheduling system and would have to look into it. On 3/26/25 at 9:30 AM the DON said that after going through the electronic scheduling it was determined that LPN J was the nurse assigned to R101 on 2/6/25 during the PM shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 9:50 AM LPN J was interviewed via phone. LPN J said, I don't know what assignment I worked that night (2/6/25). I don't recall that far back. I have never cared for that resident (R101) and usually don't work that unit. LPN J was asked about the medication administration process and replied. I always sign out my medications after I give them. If the MAR is blank, I didn't give the meds. On 3/26/25 at approximately 10:15 AM the Nursing Home Administrator (NHA) and the DON acknowledged that there was no accurate way to determine which nurse was assigned to R101 on 2/6/25 during the PM shift. The NHA said, Since the nurse did not document anything for that time-frame we can't determine what nurse was assigned to the resident. Our electronic scheduling system only reports nurses that are scheduled to work and when they 'clock -in'. It doesn't tell us what unit the nurse is assigned to work.