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	02/19/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2735896.Based on interview and record review the facility failed to implement adequate supervision for one cognitively intact resident (R903) from three residents reviewed for safety resulting in R903 exiting the building with family unbeknownst to the facility and unknown whereabouts. Findings include: The State Agency received an anonymous complaint that a resident had eloped from the facility.On 2/18/26 at 11:15 AM, the Director of Nursing (DON) was asked if a resident had eloped from the facility. The DON stated, It was not an elopement. That person was cognitively intact and thought they were going on a Leave of Absence (LOA) with friends and family. The resident was safe with family in their home. The resident said they did not know they were supposed to get permission to leave the building or they would have done that. The staff did not follow the facility's LOA process. The nurse thought the resident was on a LOA but there was no order for it. There was no information on who the resident went out with or for how long the resident would be out of the facility. On 2/2/26 during morning meeting it was reported the resident did not return to the facility from their LOA. We viewed the facility's front door camera and saw the resident was properly dressed and walked out of the facility with several family members on 2/1/26 at approximately 6:00 PM. The resident and the family member were contacted on the phone. The resident said they were returning to the facility to pick up their belongings and then wanted to be discharged . The resident was discharged Against Medical Advice.According to R903's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with diagnoses of leukemia and pneumonia. The Minimum Data Set (MDS) dated [DATE] indicated R903 had intact cognition and was independent with Activities of Daily Living including ambulation. On 1/29/26 an ‘elopement risk' assessment indicated that R903 was not at risk for elopement. A progress note written by Licensed Practical Nurse (LPN) A on 2/2/26 at 4:00 AM documented that the resident had not returned from LOA. There was no order, no care plan, and no additional documentation regarding R903 going on a LOA. On 2/19/25 at 3:40 PM, Licensed Practical Nurse (LPN) A was asked about R903. LPN A said a CNA (certified nursing assistant) told her that R903 went on a LOA with her family. LPN A stated, That's what I was told. The resident was on a LOA. LPN A could not recall the name of the CNA who told her R903 went on a LOA. LPN A said she did not look to see if R903 had an order for an LOA, or if there was any documentation regarding who the resident was with. LPN A said she did not report R903 was out of the facility until the end of the shift. LPN A said she had received an in-service from the DON on the LOA process and would go about it differently next time.On 2/19/26 at 1:34 PM Certified Nursing Assistant (CNA) B was interviewed regarding R903 and said, I noticed the resident wasn't in her room when I picked up her dinner tray around 5:30 PM- 6:00 PM. She had been with several visitors in her room earlier. When she wasn't there, I figured she went somewhere with them. I didn't even know she had not returned to her room until end of my shift when I did rounds. I asked the nurse when she would be coming back. The nurse said she had (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

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	02/19/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	until midnight to return. I wasn't worried because she was with her people. I didn't take it as an elopement, or I'd have called a code green. I thought it was a LOA. CNA B acknowledged that R903 had not been seen since early in the shift when the dinner tray was served around 5:00 PM. On 2/19/26 at 12:15 PM Receptionist (RE) D was interviewed regarding R903 and said, I don't recall anything being off that evening. I don't remember seeing that resident leave. We get a lot of visitors on Sunday. I have an elopement book with pictures of to review, but that resident wasn't on it. We now have a LOA book and are asking all visitors to sign out before they leave. There has always been that sign at the door that reminds visitors to sign out it they leave with a resident. A black sign with white lettering at the exit door asks that visitors sign out the resident at the desk if they are leaving the facility.R903 was unable to be interviewed prior to end of survey.According to the facility's Leave of Absence Policy last revised 11/16/2022 in part reads:IDENTIFICATIONS, AND CARE PLANS. Based upon the evaluation(s) completed above, the Resident's attending physician shall issue an applicable order addressing the Resident's leave classification, such as leave not permitted without approved supervision due to lack of competency or capacity; no concerns with leave; leave not recommended without-approved supervision; and/or leave not recommended with or without supervision. Additional recommendations may also be made, such as leaves not to exceed a certain number of hours or leaves at certain hours. A corresponding care plan shall also be developed and initiated. The care plan shall address any applicable clinical issues such as the Resident's possible need for medication(s) during leaves, education related to the administration of such medication, and possible dietary issues during leaves. Any other potential concerns or problems should also be addressed. Finally, the Facility shall provide a means for identifying the Resident's leave classification in the medical record, and educate staff regarding such classification. If staff are not aware of a Resident's leave classification, they shall seek clarification prior to permitting the Resident to leave the Facility.IV. LEAVE PROCEDURE1. If a Resident lacks legal competency or capacity as described above, he/she shall not be permitted to leave the Facility without approved supervision.2. If the Resident has been approved for a Leave of Absence or is Leaving the Facility Against Medical Advice, the Resident and/or Responsible Party shall make an effort to notify the Facility in advance regarding the date, time location and expected length of a planned leave of absence from the Facility.3. Residents and/or Responsible Parties shall Sign Out before leaving the Facility for a Leave of Absence by indicating the time of the leave, any family or friends accompanying the Resident during the leave, applicable contact information and the proposed location and estimated length for the leave. Residents or Responsible Parties shall also 'Sign in upon returning to the Facility following a Leave of Absence. If the Resident refuses or fails to Sign In or Out relative to a Leave of Absence, Facility staff should document such information, if known, in the medical record.4. If a Resident leaves the Facility without the Facility's knowledge and the Facility is unable to identify the whereabouts of the Resident, the leave shall be treated as an unavoidable elopement, and the Facility should implement its elopement protocol procedures.5. Staff shall document any pertinent information or concerns regarding a Resident's Leave of Absence in the medical record