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	06/10/2026

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 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 Number(s): 3022409 and 3022328. Based on interview and record review, the facility failed to report an allegation of physical abuse to the Abuse Coordinator for one (R801) of two residents reviewed for abuse. Findings include:A review of complaints submitted to the State Agency revealed allegation that R801 had a black eye and reported someone hit her. On 6/10/26, an onsite investigation was conducted. On 6/10/26 at 11:00 AM, an interview was conducted with the Administrator, who was identified as the Abuse Coordinator for the facility. The Administrator reported a detective came to the facility after receiving a concern that R801 had a black eye and said she was hit. At that time, the Administrator reported the allegation was reported to the State Agency, an investigation was conducted, and they concluded there was no evidence that abuse occurred. At that time, the Administrator provided the facility's investigation. A review of R801's clinical record revealed R801 was admitted into the facility on 7/25/25, readmitted on [DATE], and discharged on 5/30/26 with diagnoses that included: metabolic encephalopathy. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had severely impaired cognition, could sometimes make herself understood, and rarely/never understood others. R801 was assessed to be dependent on staff for all activities of daily living and mobility needs. A review of the investigation conducted by the facility revealed the following: On 5/22/26 at 2:00 PM, A detective from .police department presented to the center and asked to speak with management. The detective advised that an assault allegation had been made to the police department related to an eye injury .Per the detective's report, the resident's daughter alleges that the resident had a bruised and bloodshot eye and that the resident answered in the affirmative twice when asked if she had been hit by someone .facility is aware that in the recent days the resident had redness or a possible ruptured blood vessel in the white area of her eye, but neither the nursing department nor the attending physician suspected trauma as the cause based on the clinical presentation .no observed bruising, swelling or other injuries near the eye area have been observed .The physician evaluated the eye redness prior to today's date and did not suspect trauma . A review of a Recertification progress note written by Physician 'A', dated 5/19/26 (three days prior to the detective coming to the facility and the facility's report to the State Agency and investigation), revealed, .red left eye .The patient's daughter has expressed concern that last week the patient developed a 'red left eye.' She reports seeing the eye on Friday and noting that it appeared swollen and bruised. She also states that her mother reported 'someone hit her,' although given the patient's mentation and dementia, this report is considered unreliable. At the time of examination on Tuesday, there is minimal redness to the left eye with no evidence of ecchymosis (bruising) or swelling around the eye. The daughter has requested a CT (computed tomography) of the head, which has been ordered. Clinical suspicion for trauma at this time is low . Further review of R801's progress notes revealed redness to the left eye was first identified by the facility on 5/14/26 and the resident was evaluated by the Nurse Practitioner (NP) on 5/15/26. At that time, no trauma was suspected and the NP noted the redness most likely attributable to age-related fragility of the small conjunctival blood vessels . On 6/10/26 at 12:31 PM, an interview was conducted with (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician 'A' via the telephone. Physician 'A' reported he was familiar with the resident. When queried about what was going on with R801's eye and how he received the allegation that R801 was hit by someone on 5/19/26, Physician 'A' reported R801's daughter told him that R801 said someone hit her, but he questioned the validity of that statement due to R801's dementia and said she did not have purposeful interactions. Physician 'A' reported he evaluated R801 and there was a very minute red spot to the sclera (white part of eye) with no orbital swelling, no bruising, and no evidence of trauma that the daughter alleged. When queried about whether he reported the daughter's allegation of abuse to the Abuse Coordinator, Physician 'A' said he talked to the Administrator and DON. On 6/10/26 at approximately 12:50 PM, an interview was conducted with the Administrator. When queried about why the allegation of physical abuse alleged by R801's daughter was not reported to the State Agency until 5/22/26 when it was documented in the clinical record by Physician 'A' that the allegation was made three days earlier on 5/19/26, the Administrator reported Physician 'A' did not report the allegation to him and they discovered his note while conducting the investigation after the detective came to the facility on 5/22/26. The Administrator reported in hindsight, he would have expected Physician 'A' to discuss his clinical findings with the daughter and if the daughter still had a concern that it was due to abuse, he would have been expected to report the allegation to the Administrator. The Administrator reported that it was likely Physician 'A' did not report the allegation because the clinical presentation was not indicative of trauma when he evaluated R801, and either was the previous evaluation by the NP. A review of a facility policy titled, Abuse Prohibition Policy, revised 9/9/22, revealed, in part, the following, .Allegations by anyone who becomes aware of .physical .abuse .must immediately report it to his/her Administrator .The staff will report any allegations or suspicions of .abuse .to the Administrator and DON immediately .The Administrator or designee will notify .any State or Federal agencies of allegations .2 hours if abuse allegation .