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	05/13/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423 This citation pertains to intake MI00152511. Based on observation, interview, and record review, the facility failed to treat the resident with dignity and respect for one resident (R81) of four residents reviewed for dignity and respect, resulting in staff taking a picture of R81's buttocks, leaving the resident feeling embarrassed, ashamed, nervous, and scared. Findings include: A review of an allegation received on 4/24/2025 through the State Agency revealed the following: Complainant (R81)states that when Certified Nurse Assistant (CNA E) was cleaning (R81) up, (R81) .didn't feel like (their) bottom was clean .Complainant (R81)states that after (they) told (CNA E) that (they) didn't feel clean, CNA E took out (their) phone and took a picture of (R81's) naked bottom to show resident (R81)that (their) bottom was cleaned. Complainant (R81) states (they) talked to Registered Nurse (RN G) about the incident who told (R81) to talk to the unit Manager . On 05/06/2025 at 2:26 PM, R81 was observed sitting in their wheelchair, fully dressed, and watching TV. R81 was interviewed and asked about the incident with CNA E. R81 said, I had a BM (bowel movement) and I said that I did not feel clean. The CNA (CNA E) took (their) phone out of (their) pocket, and (CNA E) took a picture of my behind (buttock) and (CNA E) showed it (the picture) to me. R81 continued to explain that when Registered Nurse (RN G) came in, R81 told RN G what happened. At that time CNA E showed the picture to RN G. R81 stated, I was told that they wrote (CNA E) up . (CNA E) doesn't take care of me anymore. R81 was asked how they felt about the incident and R81 stated, This made me feel embarrassed and ashamed. I need a new home, but I can't take care of myself. On 05/07/2025 at 2:41 PM, R81 was observed in bed watching TV. R81 was asked how their day was going and R81 stated, I'm nervous about this (the picture) because I don't know if (CNA E) erased it (the picture) from (their) phone .that's abusive .I don't feel safe in here. A review of R81's electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Hypertension, Heart Failure, Type 2 Diabetes, Morbid Obesity, Asthma, Peripheral Vascular Disease, Epilepsy, Obstructive Sleep Apnea, Lymphedema, and Anxiety. A review of R81's Brief Interview for Mental Status (BIMS) dated 04/16/2025 disclosed a score of 15/15 (cognitively intact). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R81's care plan revealed the following: Focus: (R81) has a functional ability deficit and requires assistance with self-care/mobility R/T (related to): Impaired Mobility .Date Initiated: 01/08/2025 . Interventions: Encourage to participate in self-care as much as able, provide positive reinforcement for all activities attempted, praise resident for all efforts and accomplishments. Date Initiated: 01/08/2025 .Explain all procedures/tasks before starting. Date Initiated: 01/08/2025 . Interventions: TOILET HYGIENE: Resident Substantial/maximal assistance .with (one, two) helper(s). Date Initiated: 01/15/2025 . Focus: (R81) has the potential for fluctuations in mood R/T: DX (diagnosis): Anxiety. Date Initiated: 02/22/2025 . Interventions: Approach in a calm, quiet manner. Maintain appropriate body language during interactions such as maintaining eye contact and sitting in a relaxed position. Date Initiated: 02/22/2025 . Interventions: Observe and report to SW (social worker) and/or physician prn (as needed) acute changes in mood or behavior; feelings or sadness; increased anxiety/agitation, depression, withdrawal/loss of pleasure and interest in activities; feelings of worthlessness or guilt .how resident interacts with others. Date Initiated: 02/22/2025. On 05/07/2025 at 3:14 PM, the Director of Nursing (DON) was interviewed and informed R81 acknowledgement of not feeling safe in the facility. The DON was queried if they were aware of the accusation of (CNA E) taking a photo of R81's buttocks. The DON answered, Yes we are. The DON then explained that they investigated CNA E and had suspended CNA E. The DON said that R81 did not believe CNA E properly cleaned their behind . CNA E took the photo to prove that R81 was cleaned. The DON specified that R81 said that (they) were 'ok' with CNA E showing only (R81) the photo, but did not want the nurse to see the photo. The DON stated that R81was worried about the photo going around. The DON specified that R81 signed a document stating that R81 agreed with their plan to not allow CNA E to take care of R81 again. On 05/08/2025 at 11:53 AM, Family Member U was interviewed and queried about R81's allegation against CNA E. Family Member U said, (R81) feels that (they) will be retaliated against . (R81) talks about this (the photo) on a daily basis . (R81) cries about the picture daily .(R81) has no other place to go if they (the facility) put (R81) out. Family Member U then stated, I'm upset because (R81) does not deserve this. What happens to staff having empathy. On 05/08/25 at 12:05 PM, an attempt was made to contact RN G. The voice message box was not set-up. On 05/08/2025 at 12:13 PM, Social Worker V was interviewed about R81 asserting that they did not feel safe in the facility and was queried about not having documentation in the electronic medical record related to the incident and the resident's psychosocial needs. Social Worker V stated, I'm not sure why staff did not document in the medical record on 4/24, but we did follow up with the resident and (R81) said that (they) was safe. No further explanation was provided. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/2025 at 12:20 PM, RN K was interviewed and queried about R81 stating that they don't feel safe in the facility. RN K said, I talked to the resident (R81) yesterday and the resident said that (they) felt safe. (R81) said that (they) felt a little uncomfortable and a little scared but safe . A review of the electronic medical record's progress notes did not disclose any notes by staff related to R81 incident of photo of their buttocks from 4/23/2025-5/6/2025. On 05/08/2025 at 1:00 PM, R81 was observed in bed, eating lunch. R81 said that they still felt nervous and felt that the facility might retaliate against (them). On 05/12/2025 at 10:40 AM, CNA E was contacted by phone and interviewed about the allegation of the photo taken of R81's buttocks. CNA E stated, I went into clean (R81) .R81) kept saying I did not clean (their) behind good .I ask (R81) if (they) wanted to see it and (R81) said yes . I know it was wrong .I know it was wrong . I asked (R81) if I could take a picture (of their behind) and (R81) said yes .I took the picture of (R81's) behind, I showed it to (R81) .I showed the picture to (RN G) and then deleted it, I deleted it from the cloud . CNA F helped me with cleaning (R81). I was suspended for 3 days .My supervisor educated me .I was not trying to be malicious. CNA E was asked if they were supposed to have their phone on them and take pictures of residents. CNA E said, We are not supposed to have our phone on the floor . Afterwards they educated everyone about not having their phone on the floor. On 05/12/2025 at 11:55 AM, CNA F was interviewed and queried about CNA E taking a picture of R8's buttocks. CNA F said, CNA E wanted me to assist with cleaning (R81) . (R81) did not think (they) was clean, CNA E asked (R81) if (they) wanted a picture. (R81) did not say yes or no. So, I took it as a yes . CNA E took the picture and showed it to (R81). On 05/12/25 at 12:16 PM, the Nursing Home Administrator (NHA) was interviewed and queried about R81, residents dignity and respect. The NHA stated, We come here to care for others, it's the expectation that staff treat residents with dignity. A review of the facility's policy Resident Dignity & Personal Privacy dated 3/12/2025, revealed the following: Policy: The facility provides care for residents in a manner that respects and enhances the resident's dignity, individuality, and personal privacy. Information: Each resident's right to personal privacy includes the confidentiality of his or her personal and clinical affairs. Dignity means that when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth. A review of the facility's policy Telephone, Pager and Electronic Devices dated 6/1/2024, revealed the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	POLICY: It is the policy of this facility that, unless specifically designated otherwise, cellular phones, IPods, tablets, MP3 players, pagers or any other electronic devices are not permitted to be worn or used in any area outside of the designated staff member break room. Company telephones will be limited to certain areas and times within the workplace. Fundamental Information: In this age of technology, cellular telephones, phones with cameras, pagers and other electronic devices increase the risk of HIPAA and resident privacy violations. Although cellular phones are equipped with cameras and video recording, staff members are strictly prohibited from taking any pictures or videos in any resident area of the facility using personal cell phones. Telephone Guidelines read in part the following: 4. Personal cellular telephones, pagers or other electronic devices are only permitted to be used in the staff member designated break room during meal periods and designated break periods.

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F 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide immediate access to any resident. 47964 Based on observation, interview, and record review the facility failed to provide timely required information upon facility entry and during the annual recertification survey affecting all residents who reside in the facility causing a delay in the survey process. On 5/5/2025 at 8:30 AM upon facility entry the survey team leader requested a facility census, a resident list, and facility matrix from Registered Nurse (RN) H. RN H did not provide the requested information. On 5/5/2025 at approximately 9:15 AM the facility census, resident list, WIFI access, and facility matrix were requested from the Director of Nursing (DON). On 5/5/2025 at approximately 9:45 AM the Nursing Home Administrator (NHA) provided the facility census, resident list, facility matrix, electronic medical record (EMR) access and WIFI access. The facility provided WIFI access did not work throughout the survey. On 5/5/2025 at 9:56 AM the NHA was emailed the entrance conference worksheet which stipulates the timeframe for documents and information to be provided to the survey team. On 5/5/2025 at 10:06 AM the entrance conference was performed with the NHA. The NHA was provided with access to Egress (the State Agency electronic file sharing platform) and indicated they were familiar with the program. On 5/6/25 at 4:16 PM the NHA was interviewed regarding the delay in providing survey requested documents and said they did not have full access to the clinical portions of the EMR. The NHA further said DON was new and was getting acclimated to the EMR system. On 5/07/2025 at 3:04 PM the hospice agreements, and dialysis contracts were requested due to the correct information not being provided on day one of the survey within four hours of facility entry. On 5/12/25 at 12:25 PM the DON was interviewed regarding the delay in providing the survey team with the required survey information timely and said any of the unit managers should be able to provide a census upon surveyor entry to the facility. The DON agreed that the survey team was not provided timely documentation upon entry to the facility.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423 Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment in a timely manner for one resident (R134) of one resident reviewed for MDS assessments, resulting in the potential for inaccurate and inadequate care plans. Findings include: A review of R134's electronic medical record revealed an admission to the facility on [DATE] with the diagnosis of acute pancreatitis. R134's Brief Interview for Mental Status (BIMS) revealed a score of 15/15 (cognitively intact). R134 was discharged from the facility on 11/27/2024. A review of R134's electronic medical record revealed the Minimum Data Set (MDS) being over 120 days. On 05/12/2025 at 12:48 pm, the Minimum Data Set (MDS) MDS Nurse Y was interviewed and queried about the MDS assessment being over 120 days. The MDS Nurse Y did not respond when queried about receiving alerts of late assessments. On 5/12/2025 at 1:15pm The Director of Nursing (DON) was interviewed and queried about the MDS assessment being over 120 days. The DON said that the MDS nurse should follow the policy for MDS assessments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record the facility failed to develop and implement care plan interventions to monitor, prevent and accident for one resident (R54) of 29 residents reviewed, resulting in a potential for a unsafe environment. Findings include: On 5/7/25 at approximately 2:30 P.M. during an observation R54's call light was on the floor, out of reach and the resident was unaware of the location of the call light. R54's bed was positioned at the highest height as the resident asked for an aide and/or nurse. R54 repeated the request stating, I feel sick. Nurse Aide HH responded, summoning assistance from nurse DD voicing symptoms and concerns of the resident. On 5/7/25 at 3:27 P.M. during an observation, after care had been provided to R54, nurse aide HH was interviewed about the location of the resident's call light. The aide acknowledged the resident's call light was out of reach and someone had just left out of R54's room after caring for the resident. Nurse DD who went back into R 54' s' room was shown the hydrogen peroxide, on the resident's bedside table. Nurse DD was informed of the comet cleaner observed on 5/6/25 on the resident bed side table. Nurse DD stated, R 54' s' family visited frequently, and staff suspected the family brought the items and left them without informing staff. The family in the past has left all kinds of things including (food) and staff could not get R54 permission to discard the items. R54 should not have hydrogen peroxide or comet cleaner. Nurse DD was asked how the facility had addressed the concern with the family. Nurse DD indicated the concern should have been care planned and the family should have been educated. On 5/8/25 at 10:30 A.M. review of the care plan section of the electronic medical record revealed no interventions, education, Interdisciplinary notes or meetings or care plans were developed addressing the family's ongoing behavior of leaving items unsafe for R54. Nurse DD indicated staff should have informed UM A so it could have been addressed during care conference. In a follow up interview UM A denied knowledge of the concern with R54's family. Review of the Admission Record stated R54 was admitted to the facility on [DATE], with diagnoses of rheumatoid arthritis, dysphagia, lower back pain, diabetes mellitus with diabetic neuropathy, hypertension, acute kidney failure and spinal stenosis. On 5/13/25 at 9:00 A.M. review of the facility's policy Titled: Care Planning dated 3/3/2025, in part stated: Residents will be assessed as they are admitted , and readmitted to the nursing facility to determine their physical, psychological, emotional, medical and psychosocial needs. The results of the Interdisciplinary assessments will be used to develop, review and revise the resident's comprehensive care plan.

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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** 50634 Based on observation, interview and record review, the facility failed to ensure that one resident (R408) of one resident reviewed for dialysis services had timely and complete physician orders for dialysis, restrictions associated with an arteriovenous (AV) fistula, and clearly defined fluid restriction parameters. This failure created the potential for missed treatment, compromised vascular access and inadequate fluid management. Findings Include: On 5/7/2025 at approximately 11:00 AM, observed R408 had three cups of liquid at her bedside. There was also one liter bottle of juice on the bedside table directly behind R408. On 5/7/2025 at 11:30 AM, a review of R408's clinical medical record was conducted. The electronic medial record (EMR) lacked a physician order for dialysis. No orders were noted to restrict staff from obtaining blood pressures on R408's left arm, which contained an AV fistula used for dialysis. The EMR review indicated unclear directives regarding fluid restrictions for R408, lacking specific guidance on how staff measure and monitor fluid intake. Review of documentation revealed the blood pressures were recorded on R408's left arm despite the presence of an AV fistula on the following dates: 5/1/2025 at 6:30 PM, 5/5/2025 at 4:28 PM and 5/5/2025 at 11: 56 PM. During an interview on 5/7/2025 at 1:28 PM, the Unit Manager License Practical Nurse, (LPN) B verified that no dialysis order was present under the medical orders tab in the EMR. After 10 minutes review of the EMR, LPN B located a special instruction indicating the R 408's dialysis schedule. However, this special instruction was not visible on the surveyor's Point Click Care screen. LPN B was uncertain whether the special instructions qualified as a medical order. On 5/7/2025 at 2:00 PM, the Director of Nursing (DON), was interviewed and acknowledged that R408 special orders are not located under the medical orders. The DON was unclear if special orders were considered qualified medical orders. On 5/7/2025 at 3:52 PM, a verbal order was entered into the EMR for R408 to attend dialysis at Second Avenue Dialysis of [NAME] Health on Tuesday, Thursday and Saturday 12:05 PM with a pickup time of 11:05 AM Prior to this order, no formal medial order for dialysis was present. Record review, showed that resident R408 was admitted on [DATE] with a significant diagnosis including end stage renal disease, bacteremia, dependency on dialysis and urinary tract infection. A minimum data set assessment dated [DATE] indicated that R408 was cognitively intact scoring 13 out of 15 on the brief interview for mental status. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Hemodialysis with a revision date of 3/5/2025. The guidelines said that a physician order should be obtained for hemodialysis. In addition, if a dialysis resident is on fluid restrictions they must be monitored for compliance.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record review the facility failed to assist in the removal of facial hair and ensure showers were provided for one female resident (R54) and provide nail care for three residents (R10, R17, R100) of 29 residents reviewed, resulting in unmet hygiene needs and the potential for feelings of diminished dignity. Findings included On 5/6/25 at 12:24 PM R54 was observed with excessive hair on the chin and both sides of the lower face. The resident had dark matter protruding from the nail bed of the left index finger. On 5/7/25 at approximately 2:00 PM the facial hair and dark matter under the left index finger were still present. R54 asked how long the facial hair had been present? R54 stated during shower days she was able to remove the facial hair, however, R54 stated she had not received a shower recently because of the pain from arthritis and that alone made her sad and down. R54 stated I am supposed to get a shower on Wednesday and Saturday each week on the day shift, it's been a while, I cannot do it without help. Review of the Shower Logbook on the unit revealed R54 had one undated shower sheet, with a note stating, asked to get one in morning. The shower sheet was signed by CNA GG. While reviewing the shower Logbook nurse DD was asked for assistance in locating other shower sheets for R54. Nurse DD reported the old shower sheets were pulled off the units for audit and filing and Unit Manager A probably could provide additional information where the old shower sheets were filed. UM A joined the search for R54's shower sheets and indicated documentation of the resident's showers and or refusal should be in the nurse Aides kiosk on the unit. The manager requested the assigned nurse aid for that shift to provide a copy of last month's shower sheet from the kiosk. The information could not be retrieved from the kiosk and UM A stated I will find out how to get the document. While reviewing the One shower sheet the Electronic Medical Record was reviewed for refusals for R54. There were no entries by the nursing staff indicating R54 refused showers or was resistant to staff assisting with the removal of the facial hair On 5/12/25 at 2:00 P.M. of the Admission Record stated R54 was readmitted to the facility on [DATE], with diagnoses of rheumatoid arthritis, dysphagia (oropharyngeal) low back pain, diabetes mellitus, with diabetic neuropathy, hypertension, acute kidney failure, spinal stenosis, lumbar region with neurogenic claudication. According to the minimum data set (MDS) 2/3/2025 R54 required supervision or touching assistant with shower/bath , assistance with personal hygiene. 47964 Resident # 10 (R10) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/06/25 at 11:31 AM, Guardian I was interviewed about R10's care and said sometimes R10 does not get his nails cut. On 5/07/25 at 9:20 AM, R10 was observed with observed long jagged fingernails. On 5/08/25 09:24 AM, R10 was observed with long jagged fingernails. On 5/12/25 at 10:23 AM, R10 was observed with Registered Nurse (RN) J. RN J said int R10 had long dirty nails and they need to be cut. Record review of R10's EMR revealed he was admitted to the facility on [DATE] with diagnoses that included Acute Cerebral vascular insufficiency (obstruction of blood flow to the brain) and dysphagia. Review of the MDS dated [DATE] for R10 revealed a Brief interview for Mental Status (BIMS) of 0/15 which indicated severe cognitive impairment and dependent assistance for personal hygiene. Review of the EMR did not reveal refusals of care. Review of the Kardex revealed, Observe finger and toenails on shower days to see if they need to be trimmed. Resident #17 (R17) On 5/06/25 at 11:04 AM, R17 was interviewed about care in the facility and said she gets showers. R17's fingernails were observed long and jagged. On 5/08/25 at 10:22 AM, R17 was observed with Registered Nurse (RN) K. RN K said R17 had debris under her finger nails they needed to be clipped. Record review of R17's EMR revealed he was admitted to the facility on [DATE] with diagnoses that included Paraplegia (paralysis affecting the lower half of the body). Review of the MDS dated [DATE] for R17 revealed a BIMS of 12/15 which indicated moderately cognitive impairment and substantial/maximal assistance for personal hygiene. Review of the Kardex revealed, Bathing: Resident requires Physical help limited to transfer only, Physical help in part of bathing activity assistance with (no-setup, set-up, one, two) staff assistance to bath, observe finger and toenails on shower days to see if they need to be trimmed. Review of the EMR did not reveal refusal of care. Resident #100 (R100) On 5/06/25 at 10:51 AM, R100 was interviewed about care in the facility and stated, They don't do enough; my nails are long. R100's fingernails were observed long and jagged. (continued on next page)

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	235422	A. Building B. Wing	05/13/2025

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/08/25 at 10:06 AM, R100 was observed with RN K. RN K said R100's fingernails were long and needed to be trimmed. Record review of R100's EMR revealed he was admitted to the facility on [DATE] with diagnoses that included Epilepsy, Hemiplegia and Hemiparesis (weakness) following Cerebral Infarction (stroke) affecting Right Dominant Side. Review of the MDS dated [DATE] for R100 revealed a BIMS of 11/15 which indicated moderate cognitive impairment and dependent assistance for personal hygiene. Review of R100's Kardex revealed, Observe finger and toe nails on shower days to see if they need to be trimmed. Review of the EMR did not reveal refusals of care. On 5/12/25 at 12:25 PM, the Director of Nursing (DON) was interviewed and said the Certified Nursing Assistants should check on shower days and during regular care to see if residents' nails should be cut and/or cleaned. On 5/8/2025 at 3:03 PM, an Activities of daily living, shower and nail care policies were requested and not received by survey exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review the facility failed to ensure wheelchair footrests were in place during a wheelchair transfer and to assist with seated posture for one resident (R19) of two residents reviewed for positioning resulting in the potential for injury. Findings include: On 5/06/25 at 11:46 AM, R19 was observed sitting in the second-floor dining room participating in an activity. R19 appeared seated in a slouched position in the wheelchair without footrests with her feet dangling in the air. Activities Assistant (AA) R was observed leading the activity. On 5/06/25 at 11:53 AM, AA R was observed pushing R19 down the hallway in a wheelchair. The wheelchair did not have footrests. R19 was observed seated in a slouched position leaning back with her feet dangling in the air. On 5/06/25 at 12:30 PM, R19 was interviewed regarding the lack of footrests on her wheelchair. R19 stated, The girls don't put on the footrests to my chair. They take them off and don't put them back on. On 5/06/25 at 2:32 PM, R19 was observed sitting in the second-floor dining room slouched leaning back with no footrests applied to her wheelchair. On 5/08/25 at 2:52 PM, AA R as interviewed and said residents should be transported with footrests on the wheelchairs to prevent injury. AA R acknowledged she transported R19 in a wheelchair without footrests. Record review of R19's Electronic Medical Record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses that included Cerebrovascular Disease (condition affecting the brain blood vessels) and Vascular Dementia. Review of the Minimum Data Set (MDS) dated [DATE] for R19 revealed a Brief interview for Mental Status (BIMS) of 11/15 which indicated moderate cognitive impairment and dependent assistance for mobility. On 5/12/25 at 12:25 PM, the Director of Nursing (DON) was interviewed and said residents should have footrests on the wheelchairs during transportation and for positioning, so they are safe and won't slide out of chair. Review of the facility provided document titled Patient education how to use a manual wheelchair revised 1/27/21 revealed in part: Be sure footrest are down when the wheelchair is moving. These keep feet from dragging and getting injured.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423 Based on observation, interview, and record review the facility failed to provide pressure ulcer care per health care provider order and standards of clinical practice for two Residents (R121 and R143) of four Residents reviewed for wound care, resulting in incorrect wound care, and the potential for wound worsening, infection, and overall deterioration in health status. Findings include: Resident # R121 On 05/06/25 at 9:22 AM, R121 was observed in bed, fully dressed, and watching TV. R121 was observed to have a left above the knee amputation (Above-the-knee amputation (AKA) involves removing the leg from the body by cutting through both the thigh tissue and femoral bone). R121 said they had had recent surgery about a month ago due to an infection. R121 indicated that staff changed their wound dressings daily. A review of R121's electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Atrial Fibrillation, Heart failure, Chronic Obstructive Pulmonary Disease, Depression, Weakness, Left Amputation, Peripheral Vascular Disease, and Cocaine Abuse. R121's Brief Interview for Mental Status (BIMS) dated 04/18/2025 disclosed a score of 15/15 (cognitively intact). A review of R121's care plan revealed the following: Focus: (R121) has Actual impairment to skin integrity r/t (related to) Surgical incision to LBKA (left below the knee amputation) and right 4th and 5th digit. Date Initiated: 02/11/2025 . Interventions: Follow facility policies/protocols for the prevention/treatment of impaired skin integrity. Date Initiated: 02/09/2025 . On 05/07/25 at 10:12 AM, R121 was observed sitting in bed, watching TV. Wound Care Nurse AA applied a pair of gloves and removed the dressing from the left stump. The stump surgery wound was opened towards the inner thigh. There was a small amount of serosanguineous drainage without odor. Wound Care Nurse AA cleansed the wound with normal saline, pat dried, applied Santyl Ointment applied, Maxorb dressing was applied, lastly, the wound was covered with ABD pad and wrap with a kerlix. Wound Care Nurse AA removed the dressing to R121's right foot. The 4th and 5th toes had open areas at the bottom of the right foot with bloody drainage. Wound Care Nurse AA Cleanse in between the 4th and 5th digit with wound cleanser, pat dried, and applied a soaked betadine gauze and wrapped the foot with an ace wrap. Wound Care Nurse AA wrapped the right foot 4th and 5th toes with an ACE wrap, not the ordered kerlix and secured with tape. A review of the physician's wound care order dated 05/06/2025 revealed the following: Cleanse right in between the 4th and 5th digit with wound cleanser, pat dry. Apply a soaked Betadine gauze wrap with kerlix and secure with tape. Resident #R143 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/25 at 12:30 PM, R143 was observed sitting in a wheelchair, watching TV. R143 indicated that they had been in an accident and was paralyzed from the waist down. R143 said that they suffered a gunshot wound in their neck in November 2024. R143 was queried about their pressure ulcer. R143 stated, I got the bed sores when I first went to the hospital .I guess it was more important to save my life than to prevent bed sores. A review of R143 electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Gunshot wound, Major Depression, Weakness, and Unstageable Sacral Pressure Ulcer. R143's Brief Interview for Mental Status (BIMS) dated 2/11/2025 disclosed a score of 12/15 (Moderate cognitive impairment). A review of R143's care plan revealed the following: Focus: (R143) is at risk for impaired skin integrity/pressure injury R/T (related to): GSW (gunshot wound), generalized weakness, impaired mobility, and incontinent of bowel and bladder. Date Initiated: 01/30/2025 . Interventions: Follow facility policies/protocols for the prevention/treatment of impaired skin integrity. Date Initiated: 01/30/2025 . Focus: R143 has Actual impairment to skin integrity r/t pressure injury to sacro-coccyx Date Initiated: 01/30/2025 . On 5/07/25 at 10:38 AM, R143 was observed in bed, on their left side watching TV. Wound Care Nurse AA applied a pair of gloves and untaped R143's brief, pulled the brief slightly down to view the wound. The wound was located at the sacrum, stage three pressure ulcer, with a small amount of serosanguineous drainage. The wound bed was pink and without odor. Wound Care Nurse AA removed R143's wound dressing. Wound Care Nurse AA cleansed sacrococcyx with wound cleanser and pat dry. Wound Care Nurse AA applied Maxorb AG dressing, and ABD dressing. Wound Care Nurse AA did not secure R143 wound with a secure border gauze as ordered. A review of the physician's wound care order dated 4/05/2025 revealed the following: Cleanse sacrococcyx with wound cleanser and pat dry. Apply Maxorb AG and ABD pad and secure with border gauze. When Wound Care Nurse AA was informed that they did not follow the physician's order for the wound dressings of R121 and R143, Wound Care Nurse AA stated, Oh, you right. No additional explanation was provided. On 5/12/25 at 12:25PM, the Director of Nursing (DON) was interviewed and queried about Wound Care Nurse AA not following the physician's wound treatment order for R121 and R143. The DON stated, The wound care nurse should follow the physician orders. A review of the facility' policy Physician Order dated 10/20/2023 revealed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: Physician orders are obtained to provide a clear direction in the care of the resident. Treatment rendered to a resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review the facility failed to provide adequate foot care for one resident (R100) out of eleven residents reviewed for Activities of Daily Living (ADLS). Findings include: On 5/06/25 at 10:51 AM, R100 was interviewed about care in the facility and stated, They don't do enough, my nails are long. R100s feet were observed with thick long toenails and dry flaky skin. On 5/08/25 at 10:20 AM, R100's feet were observed with Registered Nurse (RN) K. RN K described R100's feet as having long thick toenails and flaky skin on feet and that R100 should see the podiatrist. RN K asked R100 if he would like podiatry services and R100 agreed. Record review of R100's Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses that included Epilepsy, Hemiplegia and Hemiparesis (weakness) following Cerebral Infarction (stroke) affecting Right Dominant Side. Review of the Minimum Data Set (MDS) dated [DATE] for R100 revealed a Brief interview for Mental Status (BIMS) of 11/15 which indicated moderate cognitive impairment and dependent assistance for personal hygiene. Review of R100's Kardex revealed, Observe finger and toenails on shower days to see if they need to be trimmed. Review of the EMR did not reveal refusals of care. Review of the physician orders dated 12/27/2023 revealed, Podiatry Evaluation and treatment as indicated. On 5/8/25 at approximately 4:00 PM, Social Worker (SW) V provided documentation that R100 was last seen by podiatry on 9/4/2024. When asked how frequently should R100 see the podiatrist for care SW V did not provide an answer but provided documentation that the podiatrist saw R100 on 5/8/2025 after the care needs were brought to the facility's attention. On 5/12/25 at 12:25 PM, the Director of Nursing (DON) was interviewed and said the Certified Nursing Assistants should check on shower days and during regular care to see if residents' nails should be cut and/or cleaned. The DON also said podiatry should have seen R100 sooner. Eight months between visits was not timely. Review of the facility policy titled Social services Referral to Outside Providers revised 10/27/2023 revealed in part: Referrals to ancillary providers will be made in order to meet the psychosocial and/or concrete needs of a resident. A social service staff member, a licensed nurse, or a member of the interdisciplinary team will make the referral based on a resident's individualized, specific needs as identified through interviews, evaluations and assessments.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review the facility failed to apply splints and provide Range of Motion (ROM) exercises for one resident (R100) out of four residents reviewed for limited ROM. Findings include: On 5/06/25 at 10:52 AM, R100 was observed in bed with his right elbow and right hand bent not wearing a brace or splint. On 5/07/25 at 10:13 AM, R100's splints were found in his dresser top drawer. When asked about the braces R100 stated, They don't put the splints on me they have too much to do. I would allow it, but they aren't doing it. On 5/08/25 at 10:27 AM, Certified Nursing Assistant (CNA) X was interviewed and said they were not applying R100's splints or performing a ROM program with him. On 5/08/25 at 10:28 AM, Registered Nurse (RN) K was interviewed and said the facility did not have a restorative nurse or aides and the CNAs were responsible for applying splints and performing exercises. RN K said she was new to the position. On 5/08/25 at 10:33 AM, Restorative Nurse Y was interviewed and said the facility just started a new program. R100's EMR was reviewed with Restorative Nurse Y and did not reveal any documentation of brace application and/or ROM exercises or refusals since 4/19/2025. Record review of R100's Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses that included Epilepsy, Hemiplegia and Hemiparesis (weakness) following Cerebral Infarction (stroke) affecting Right Dominant Side. Review of the Minimum Data Set (MDS) dated [DATE] for R100 revealed a Brief interview for Mental Status(BIMS) of 11/15 which indicated moderate cognitive impairment and dependent assistance for personal hygiene. Review of R100's Kardex revealed, Apply splint to right hand and right elbow alternating 4-5 hours or as tolerated per order/recommendation. AROM (active ROM) exercises to left upper extremity 2 sets x 15 reps. On 5/12/25 at 12:25 PM, the Director of Nursing (DON) was interviewed and said the CNAs should be following the Kardex and applying R100's braces and performing the ROM exercises with him. The DON said R100 was at risk for worsening contractures without the restorative program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Restorative Nursing revised 4/26/2024 revealed in part: The facility strives to enable the residents to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being. The interdisciplinary team (IDT) works with the residents and family to identify measurable restorative goals and practical interventions that can be implemented and achieved with nursing support. A licensed nurse will help manage the restorative nursing process with assistance of nursing assistants trained in restorative care. Sometimes, under licensed nurse supervision, other staff trained in restorative care will be assigned by the nurse to work with specific residents. Nursing Restorative is available up to 6-7 times per week and is provided for residents meeting restorative program criteria. Document any refusal in the resident's medical record. Document individualized restorative goals and interventions. Please reference the Restorative Goal/Intervention Reference policy. Document the resident's daily participation and actual number of minutes participating in in the resident's EHR (electronic health record).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record review the facility failed to ensure one resident (R54) of 29 residents was free from accident hazards as a results of the resident's call light not being within reach and potentially hazardous products left at the resident's bedside, resulting in a potential for an accident to occur. Findings include. On 5/6/25 at 12:28 P.M., (R54) was observed in bed with the call light entangled in the linen. On the bedside table was a container of hydrogen peroxide and a container of Comet household cleaner. On 5/7/25 at approximately 2:30 P.M. during an observation R54's call light was on the floor, out of reach and the resident was unaware of the location of the call light. R54's bed was positioned at the highest height as the resident asked for an aide and/or nurse. R54 repeated the request stating, I feel sick. Nurse Aide HH responded, summoning assistance from nurse DD voicing symptoms and concerns of the resident. At 3:27 P.M. after providing care to R54 nurse aide HH was asked about the armrests of the resident's wheelchair. The aide acknowledged the armrests needed repair and R54 needed a Geri chair which would allow the resident the ability to sit comfortably without sliding out of the chair. The Aide who entered the room after R54 requested assistance commented R54's call light should always be in reach. Nurse DD who went back into R54's room was shown the hydrogen peroxide, on the resident's bedside table. Nurse DD was informed of the comet cleaner observed 5/6/25. Nurse DD stated, R54's family visited frequently, and staff suspected the family brought the items and left them without informing staff. The family in the past has left all kinds of things including (food) and staff could not get R54 permission to discard the items. R54 should not have hydrogen peroxide or the comet cleaner, the facility provides any medication or treatment, and housekeeping staff do not clean the rooms with comet cleaner. Nurse DD was asked how the facility had addressed the concern with the family. Nurse DD indicated the concern should have been reported to the Unit Manager A and staff should have educated the family on safety. On 5/8/25 at 10:17 A.M. UM A was interviewed about the items at the bedside of R54. UM A was unaware of the family leaving items that the resident should not have. Record review at the time of the interview revealed no evidence of family education, notes by nursing staff related to the family bring items into the facility or interventions Review of the Admission record stated R54 was admitted to the facility on [DATE], with diagnoses of rheumatoid arthritis, dysphagia, low back pain, diabetes mellitus with. diabetic neuropathy, hypertension, acute kidney failure and spinal stenosis, lumbar region with neurogenic claudication (limping condition). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Minimum Data Set (MDS) assessment dated [DATE], R54 had impaired thought process and cognitive function (ability to think), incontinent of bowel and bladder, and required one-person physical assist to Perform activities of daily living.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview, and record review the facility failed to ensure respiratory equipment was maintained in a sanitary manner for one resident (R28) of three residents reviewed with oxygen, resulting in the potential for compromised air exchange. Findings include: On 5/6/25 at 11:30 A.M. during an observation R28 was observed with oxygen infusing at 3.5 Liters per minute via Nasal Cannula. Attached to the oxygen tubing which was dated 5/5/25 was an oxygen concentrator (a medical devices that provides extra oxygen. An oxygen concentrator uses the air in the atmosphere, filters it and gives you air that is 90%-95% oxygen). On 5/7/25 at approximately 12:00 P.M. record review revealed R28 was signed into hospice on 3/7/25 and the comprehensive plan of care, and the hospice consent were faxed to the facility on [DATE]. Review of the provided contract and delegated responsibilities of each entity did not identify who was responsible for the maintenance of the oxygen received by R28. On 5/7/25 at 12:30 P.M. during an observation the date on the oxygen tubing was observed changed to 5/7/25. During this time Hospice Aide Z was observed providing care to R28. The aide was asked about the services provided by her and whether the company the aide worked for changed or cleaned the air filter. Hospice Aide Z indicated being responsible for placing the oxygen back on R28 once care was provided and assisting with activities of daily living. Hospice AideZ stated I do not have anything to do with that part of R28's care. I have been with R28 since the resident signed on to receive services from the company I work for. On 5/7/25 at 12:45 P. M. Nurse P was interviewed regarding the maintenance of the oxygen for R 28. Nurse P stated you can check with maintenance, but nursing does not provide oxygen care. Following the discussion with Nurse P an observation was made of R 28' s' oxygen filter. Upon examination the filter was observed covered with a layer of lint and dirt that was visible on the hand of the surveyor. On 5/7/25 at approximately 4:30 PM a review of R 28's electronic medical record (EMR) revealed a re-admitted [DATE], with diagnoses of: Atrial Fibrillation, Hypertensive heart disease with heart failure, Type 2 Diabetes Mellitus, Lymphedema, Venous Insufficiency (chronic), Dementia, without behavior, and Acute Respiratory Failure with Hypoxia. A review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE], indicated R28 was moderately impaired in cognition (the ability to think), was frequently incontinent of bowel and bladder and required extensive assistance with bed mobility and transfers. . On 5/12/25 at 9 :00 A.M review of the care plan dated 12/15/23, that addressed R28 respiratory concerns did not identify any interventions related to R28's oxygen equipment including the maintenance of filter and frequency of cleaning. A review of the order summary included a physician order for supplemental oxygen to include supplemental oxygen 2-4 L via Nasal Cannula (NC). (continued on next page)

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	235422	A. Building B. Wing	05/13/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. On 5/13/25 at 1:30PM the Director of Nursing (DON) was asked who was responsible for cleaning or maintaining the oxygen filters in the facility. The DON stated the facility had a contract company that visited the facility weekly and was responsible for changing the tubing and the filters on all the oxygen equipment. The DON reported the company should have changed the filter/or replaced the filter. It was confirmed through interview with the receptionist the contracted company had visited the facility on 5/7/25 and R 28' s' oxygen filter as well as tubing should have been addressed.

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	235422	A. Building B. Wing	05/13/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 Based on observation, interview and record review, the facility failed to ensure the security of the electronic medical record (EMR) of one resident (R306) out of 29 residents reviewed. Findings Include: On 5/7/2025 at 9:30 AM, a medication cart on unit 300 was observed left unattended with the EMR screen open and displaying R306's PHI. The cart faced the hallway, which was actively used by staff and residents, exposing confidential details to unauthorized individuals. On 5/7/2025 at 9:40 AM, Licensed Practical Nurse (LPN) C exited R306 room and, upon interview, confirmed they left the art unsecured with PHI visible. LPN C acknowledged this was not in compliance with facility protocol. 05/07/25 9:53 AM, the unit manager (LPN) B was interviewed and said the computer should have been locked, and no medications should be left unattended on the cart. 05/07/25 10:52 AM, the Director of Nursing (DON) was interviewed and confirmed staff are expected to follow facility policy regarding medication cart security, including locking the cart and screen are closed when not in use. Record review of R306's EMR revealed that R306 was admitted on [DATE] with a diagnosis of unilateral osteoarthritis of the left knee and operative recovery from a total left knee replacement. R306 also has a history of borderline diabetes, lipidemia, and hypertension. Record review of R306 for minimum data set for brief interview for mental status indicated R306 was cognitively intact with a score of 13 out of 15. Review of facility policy titled Residents Rights with a revision date of 5/14/2024. The policy stated, The facility will safeguard the privacy of residents' protected health information from improper use. Review of the policy titled Medication Administration, revised 10/17/2023, documented: Make sure the medication cart is locked at all times when not in use or not within constant vision.

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	235422	A. Building B. Wing	05/13/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423 Based on observation, interview, and record review, the facility failed to secure, label and dispose of expired medication by professional standards for two of four medication carts reviewed for secured, expired and unlabeled medications, resulting in the potential for unsafe medication administration. Findings include: On [DATE] at 12:55pm, an observation of Hall ,d+[DATE] Medication Cart was conducted with Registered Nurse BB (RN BB). The cart contained the following: -Humulin R, (insulin) U-100 - One vial expired ,d+[DATE]. - Lantus (insulin) U-100 one vial-Opened and undated. -Vitamin E Pills - one opened bottle expired ,d+[DATE] - Fish Oil Pills expired ,d+[DATE] At this time RN BB was queried regarding the expired, and undated medication. RN BB was unable to provide an explanation. On [DATE] at 1:10pm The Director of Nursing (DON) was interviewed and queried about the storage of expired and undated medication. The DON stated, Staff should follow policy for medication cart storage. A review of the facility's policy Medication Management dated [DATE] revealed the following: Medications are stored, dispensed and destroyed in a manner to ensure safety and conformance with state and federal laws . 11. Medications will be dated and discarded per manufactures guidelines . 50634 On [DATE] at 9:30 AM, a medication cart was observed left unattended in the hallway on unit 300. On top of the cart, three medications prescribed for R306 were found unsecured: Amlodipine 5 mg, Lisinopril 20 mg and Metoprolol 50 mg. On [DATE] at 9:40 AM, Licensed Practical Nurse (LPN) C was observed exiting R306's room. Upon interview, LPN C confirmed they left the cart unattended and acknowledged the medications were left unsecured on top of the cart. LPN C said they had been in R306 room taking R306's vial signs. [DATE] 9:53 AM, the unit manager (LPN) B was interviewed and said the medication cart should have been secured, and no medications should be left unattended on the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] 10:52 AM, the Director of Nursing (DON) was interviewed and confirmed the facility policy requires medication carts to be locked. The DON said staff are expected to lock all medications away when not in use. Record review of R306's EMR revealed that R306 was admitted on [DATE] with a diagnosis of unilateral osteoarthritis of the left knee and operative recovery from a total left knee replacement. R306 also has a history of borderline diabetes, lipidemia, and hypertension. Record review of R306 for minimum data set for brief interview for mental status indicated R306 was cognitively intact with a score of 13 out of 15. Review of facility policy titled 'Medication Treatment Cart Use revised [DATE] documented that no medications are to be kept on top of the cart, and the cart must remain visible to the person administering medications.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review the facility failed to ensure routine dental services were provided to one resident (R10) of three residents reviewed for routine dental services, resulting in unmet oral health needs. Findings include: On 5/6/2025 at 11:31 AM, R10 was observed in his room resident demonstrated he did not have teeth. When R10 was asked about his oral health he was not able to provide an answer. On 5/6/2025 at 11:36 AM, Guardian I was interviewed and stated, R10 needs to see the dentist to get dentures. Record review of R10's Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses that included Acute Cerebral vascular insufficiency (obstruction of blood flow to the brain) and dysphagia. Review of the Minimum Data Set (MDS) dated [DATE] for R10 revealed a Brief interview for Mental Status (BIMS) of 0/15 which indicated severe cognitive impairment and did not have the oral/dental status completed. Review of the Physician Orders dated 8/8/2024 documented Dental Evaluation and treatment as indicated. Review of the care plan did not reveal documentation to address dental concerns or a lack of teeth. On 5/08/25 at 3:27 PM, R10's dental notes were requested and were not provided by survey exit. On 5/12/25 at 8:43 AM, Licensed Practical Nurse W was interviewed and said nursing and social work does an resident assessment upon facility entry for dental needs. On 5/12/25 at 8:45 AM, Social Worker (SW) Z was interviewed and said she was not aware of R10's dental concerns however did acknowledge there was a physician order for a dental evaluation. On 5/12/2025 at 1:15 PM, the Director of Nursing (DON) was interviewed regarding R10's dental health. The DON said R10 should have been seen by the dentist and acknowledged there was an order. The DON further said the social worker department was responsible for setting up dental appointments. Review of the facility policy titled Social services Referral to Outside Providers revised 10/27/2023 revealed in part: Referrals to ancillary providers will be made in order to meet the psychosocial and/or concrete needs of a resident. A social service staff member, a licensed nurse, or a member of the interdisciplinary team will make the referral based on a resident's individualized, specific needs as identified through interviews, evaluations and assessments.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record review the facility failed to ensure the proper assistive device was provided to enhance and promote independence in eating for one resident (R126) of 30 residents observed during dining on the second floor, resulting in a potential for a decline in eating skills and abilities. Findings include: On 5/6/25 at approximately 10:00 A.M. R126 was interviewed concerning the breakfast meal. R126 was observed with two white towels rolled and positioned in each hand. R126 stated his meals were served in the restorative Dining Program. On days when R126 went to therapy, meals were left in the room and the resident fed himself. On 5/6/25 at 1:01 P.M., and 5/7/25 at 12:50 P.M., during a lunch meal observation R126 was observed being fed (1:1) by a nurse aide. R126's food was served on a regular China plate with the beverage served from a sippy cup. The tray card served with the meal on 5/6/25 stated: mechanical soft regular diet adaptive equipment: Scoop plate. On 5/8/25 at 9:00 A.M. review of the care plan dated 4/15/25, Titled :R126 has alteration in nutrition related to (r/t) diagnosis of dysphagia, GERD(condition in the gastrointestinal tract that causes excess production of hydrochloric acid, bloating and discomfort), obese status with BMI greater than 30, chewing and swallowing difficulty related to dysphagia, need for mechanical altered texture diet, self-feeding difficulties, weight loss during hospitalization . Interventions identified included: Provide diet as ordered, regular diet, mechanical soft texture, thin liquid with scoop plate at each meal. Assist with meals as needed tray set up. On 5/8/25 at 10:40 A.M. review of the physician orders dated 6/18/24 stated R126 was ordered Scoop Plate with meals. On 5/8/25 at 10:45 A.M. nurse DD was queried concerning the discrepancy in the physician orders and the serving of R126's food in a regular plate. Nurse 'DD reported R126 participated in the restorative dining program but was unaware of the recommendations from therapy for a scoop plate. On 5/8/25 at 11:07 A.M. Unit Manager (UM) A verified the physician's order indicated R126 should be using a scoop plate and a sippy cup. UM A was unable to explain why R126 was fed by staff and received regular China. AT 2:30 P.M. Dietary Aide (D.A.) EE was interviewed concerning R126's meals being served on a regular plate. D.A.EE indicated R126 at one time did receive food served from a scoop plate but the order on the tray card was new and there was no scoop plate for the resident. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at 9:03 A.M. Registered Dietitian (RD) O was interviewed concerning R126's scoop plate. RD O was unaware of the physician's order for R126's scoop plate but indicated after investigating the matter therapy was changing from the former company that was previously used to obtain scoop plates. Through the investigation of RDO it was verified, therapy never submitted the requisition for purchase of a scoop plate. The tray card was updated automatically when the order was placed, but the dietary department will not order a scoop plate without a requisition to purchase the item. Review of the Admission Record indicated R126 was admitted to the facility on [DATE], with diagnoses that included: acute respiratory failure, dysphagia (oropharyngeal phase) chronic pain syndrome, cardiovascular accident, muscle weakness, and hypertension. According to the Minimum Data Set (MDS) assessment dated [DATE], R126 was moderately impaired in cognitive skills (ability to think), required one-person physical assistance with activities of daily living (ADL's) and was always incontinent of bowel and bladder. The facility's policy related to Adaptive Equipment was requested and provided with a revised date of 3/6/2024, in part stated: It is the policy of this facility to provide adaptive eating equipment for those residents who would benefit from there use, based on comprehensive assessment to assist the resident to achieve his or her highest functioning potential.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 15194 Based on observation, interview and record review, the facility failed to ensure hygienic practices were performed while serving resident's meals, resulting in the potential for food contamination. Findings include: On 5/6/25 at 12:53 P.M. on the second floor in the dining area approximately 30 residents were observed seated in the dining room eating their lunch meals. Nursing staff were observed wrapping silverware in napkins and placing the settings on the tables for the residents. Staff entered the dining room and washed their hands but during the wrapping of the silverware touched and manipulated the eating portion of the resident's eating utensils without wearing gloves. During the meal Observation LPNM served/and assisted resident's (R61, R89 and R126) with requests for various food items. LPNM was observed with long, flowing hair that extended down her back stopping at or just below her buttocks. On 5/12/25 at 12:00 P.M. during an observation in the first-floor dining room. Nurse L (newly hired) was observed with loose, braided hair that extended down below her buttock. Nurse L was observed assisting residents with their beverage of choice and walking through the dining area to the steam table (holding food) talking to residents concerning their food and whether additional assistance was needed. During the observation Dietary manager (DM) N presence was requested. The manager indicated meals served in the dining rooms was a shared responsibility between Nursing and Dietary staff and All of the Dietary staff in the kitchen and on the units were wearing hair/beard restraints/caps or some type of head covering. Further ongoing observations were noted and staff with the loose, extended hair were identified as being nurse staff from the units. On 5/13/25 at 12:30 P.M. the Director of Nursing (DON) was interviewed concerning the use of hair restraints for nursing staff while assisting with meal service. The DON was unaware of the use of hair restraints and indicated nursing staff would be educated. According to the 2013 Food Code. Under Hygienic Practices Section 2-402.11 (A) Except as provided in (B) of this section, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record review, the facility failed to ensure relevant Hospice documentation was accessible for two residents (R28, R67) of nine hospice residents from a total of twenty-nine sampled residents, resulting in a lack of coordination of comprehensive services and care provided to the residents. Findings included: Resident # R28 (R28) On 5/7/25 at 11:57 AM nurse P was asked for the location of the Hospice Notebook for R 28. Nurse P indicated all the resident's visits should be in a binder located at the nurse's station. Nurse P searched the residents Hospice Notebook and acknowledged the visits were present, but no other hospice documentation was there. Nurse P indicated she would contact Unit Manager K. who could assist further. On 5/7/25 at 12:11 PM a review of the Hospice Notebook identified for R28 revealed there was no comprehensive assessment, consent for Hospice benefits, or Hospice comprehensive plan of care. On 5/7/25 at 12:20 PM Unit Manager (UM) K was unaware of where the documents were located and indicated further investigation was needed to determine the location of the documents. Social Worker V who accompanied UMK joined the conversation and suggested UMK would have to search for the documents, check with the administrator and the documents would be provided later. On 5/7/25 at 1:06 PM UM K submitted the requested documents, and stated the Administrator had them. UM K was asked why the requested documents were not in R28's Hospice Notebook and how did staff ensure coordination of care if there was no reference or comprehensive plan of care? The Manager indicated being in the current position for 2 weeks and was still orientating herself to the unit. Further review of the submitted documents revealed that R 28 was admitted to Hospice on 3/7/25 and the Comprehensive Plan of Care, and the Hospice Consent were faxed to the facility on [DATE]. The Comprehensive Assessment benefit period was dated 3/7/25 to 5/4/25, indicating a possible lapse in service. Review of R 28' s' electronic medical record (EMR) revealed a re-admitted [DATE], with diagnoses of: Atrial Fibrillation, Hypertensive heart disease with heart failure, Type 2 Diabetes Mellitus, Lymphedema, Venous Insufficiency (chronic), Dementia, without behavior, and Acute Respiratory Failure with Hypoxia. A review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE], indicated moderate impairment in cognition. R28 was frequently incontinent with bowel and bladder and required extensive assistance with bed mobility and transfers. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the order summary report of R28 revealed an active order dated 3/7/2025 specifying Consult with Hospice Care. Resident # 67 (R67) Review of the Admission Record of R67 indicated an admission to the facility on [DATE], with diagnoses of Acute Cystitis w/o hematuria, Dysphagia, Severe Protein Calorie Malnutrition, Pressure Ulcer of Sacral(unstageable), Vascular Dementia, Aphasia, Major Depression. According to the Minimum Data Set (MDS) assessment dated [DATE] indicated R67 was severely impaired in Cognitive Skills for decision making. R67 was incontinent with bowel and bladder and required maximal assistance for most activities of daily living (ADL's). Review of R67's Electronic Health Record indicated the resident was admitted to the same Hospice Company as R28 on 3/12/25 with a diagnosis of Lung Cancer. R67's Hospice current Comprehensive Assessment was not part of the resident's electronic health record until 5/6/25 at 12:47 PM,when R28's documents were faxed to the facility. On 5/13/25 at 1:30 PM the Director of Nursing (DON) was made aware of the concerns. The DON was asked about the location of hospice comprehensive plan of care, and consent for hospice care. The DON indicated the documents requested should be accessible for staff and placed in the resident's hospice log book. The DON wasn't able to explain why or where the documents were for R28 or R67 clinical record but acknowledged the information should have been accessible in both residents' clinical records.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 This citation has two deficient practice statements 1 and 2. DPS 1) Based on observation, interview, and record review, the facility failed to ensure staff follow enhanced barrier precautions and donned appropriate personal protective equipment (PPE) for one resident (R408) and implemented preventative measures, a sterile cap for one resident (R405) out of three residents reviewed for infection control. This failure resulted in the potential for transmission of infectious organisms. Findings include: Resident #R408 On 5/7/2025 at 11:17 AM certified nursing assistant CNA D was observed removing soiled linen from the bed of resident R408 during this task CNA D did not wear a gown as required under the Enhanced Barrier Precautions (EBP). On 5/7/2025 at 11:30 AM infection control registered nurse RN A was observed placing an enhanced barrier precautions sign on R408's door. In an interview conducted on 5/7/2025 at 11:40 AM, CNA D said that she was unaware that R408 was on enhanced barrier precautions as there was no precautionary sign visible on the residence door at the time of care. On 5/7/2025 at 11:45 AM, RN A was interviewed and said that although the EBP sign was missing from R408's door staff were expected to be aware of EBP and follow orders for EBP based on R408's medical record. Record review revealed that a physician order for EBP for R408 was entered into the electronic medical record (EMR) on 4/29/2025 prior to the observed incident. On 5/7/2025 at 11:50 AM, the Unit Manager licensed practical nurse (LPN) B was interviewed and acknowledged that enhanced barrier signs sometimes fall off residence doors. LPN B said that staff are expected to verify EBP status using the EMR or the Kardex system. On 5/7/2025 at 12:13 PM, the Director of Nursing (DON) was interviewed and confirmed that staff bagging soiled linen for a resident with an EBP must wear gloves and a gown. The DON said that each staff member is responsible for checking residents Kardex at the start of their shift to verify precautionary status. In addition, the DON said staff should repost signage for EBP if it is missing. Record showed that resident R408 was admitted on [DATE] with a significant diagnosis including end stage renal disease, bacteremia, dependency on dialysis and urinary tract infection. A minimum data set assessment dated [DATE] indicated that R408 was cognitively intact, scoring 13 out of 15 on the brief interview for mental status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enhanced Barrier Precaution policy was requested at the time of interview with the DON and RN A but was not provided. Resident #R405 On 5/07/25 at 12:16 PM, observed R405 in Physical Therapy with Peripherally Inserted Central Catheter (PICC) line dangling. The PICC line was a single lumen line, it was uncovered. The PICC line did not have a sterilization cap on the end. Record review noted that R405 was admitted on [DATE] with a pertinent diagnoses of Unilateral Osteoarthritis of Right Hip, Contracture of the Right Knee, Pain in Right Hip and Surgical Wound. Record review of R405's Minimum Data Set (MDS) dated [DATE] for Brief Interview for Mental Status (BIMS) noted R405 was cognitively intact with a score of 15 out of 15. On 5/07/25 at 12:35 PM, the Director of Nursing (DON) was interviewed and queried about R405's PICC line. The DON acknowledged that the PICC line did not have a sterile cap. The DON said the PICC line should be covered with a sterile cap. The DON directed the unit manager from 300/400 Licensed Practical Nurse (LPN) B to cover the PICC line with sterile cap. The DON said she would expect that staff would put a sterile cap on PICC line after each use. A review of the policy titled Peripherally Inserted Central Catheter (PICC) flushing and locking with a revision date of 8-19-2024 revealed when locking a locking device place an end cap on the connector to reduce the risk of vascular associated infections. 41423 DPS 2) Based on observation, interview, and record review the facility failed to ensure the provision of care per professional standards of practice were implemented for infection control practice of hand hygiene during wound care, for two Residents (R121 and R143) of three Residents reviewed for infection control, resulting in the potential for spread of infection, worsening wounds, and the potential decline in overall health status. Resident # R121 On 05/06/25 at 9:22 AM, R121 was observed in bed, fully dressed, and watching TV. R121 was observed to have a left above the knee amputation (Above-the-knee amputation (AKA) involves removing the leg from the body by cutting through both the thigh tissue and femoral bone). R121 said they had a recent surgery about a month ago due to an infection. R121 indicated that staff changed their wound dressings daily. A review of R121's electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Atrial Fibrillation, Heart failure, Chronic Obstructive Pulmonary Disease, Depression, Weakness, Left Amputation, Peripheral Vascular Disease, and Cocaine Abuse. R121's Brief Interview for Mental Status (BIMS) dated 04/18/2025 disclosed a score of 15/15 (cognitively intact). A review of R121's care plan revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: (R121) R121 has Actual impairment to skin integrity r/t (related to) Surgical incision to LBKA (left below the knee amputation) and right 4th and 5th digit. Date Initiated: 02/11/2025 . Interventions: Follow facility policies/protocols for the prevention/treatment of impaired skin integrity. Date Initiated: 02/09/2025 On 05/07/25 at 10:12 AM, R121 was observed sitting in bed, watching TV. Wound Care Nurse AA applied a pair of gloves and removed the dressing from the left stump. The stump surgery wound was opened towards the inner thigh. There was a small amount of serosanguineous drainage without odor. The Wound Care Nurse AA donned another pair of gloves without initiating hand hygiene. Wound Care Nurse AA cleansed the wound, removed their gloves and donned another pair of gloves without initiating hand hygiene. Wound Care Nurse AA applied Santyl Ointment, applied the dressing, lastly, the wound was covered. Wound Care Nurse AA removed their gloves and donned another pair of gloves without initiating hand hygiene. Wound Care Nurse AA removed the dressing to R121's right foot, removed their gloves and donned another pair of gloves. The 4th and 5th toes had open areas at the bottom of the right foot with bloody drainage. Wound Care Nurse AA removed their gloves and donned another pair of gloves without initiating hand hygiene. Wound Care Nurse AA Cleansed in between the 4th and 5th digit with wound cleanser, pat dried, and applied a soaked gauze and wrapped the foot. Wound Care Nurse AA removed their gloves and donned another pair of gloves without initiating hand hygiene. Resident #R143 On 05/06/25 at 12:30 PM, R143 was observed sitting in a wheelchair, watching TV. R143 indicated that they had been in an accident and were paralyzed from the waist down. R143 said that they suffered a gunshot wound in their neck in November 2024. R143 was queried about their pressure ulcer. R143 stated, I got the bed sores when I first went to the hospital .I guess it was more important to save my life than to prevent bed sores. A review of R143's electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Gunshot wound, Major Depression, Weakness, and Unstageable Sacral Pressure Ulcer. R143's Brief Interview for mental Status (BIMS) dated 02/11/2025 disclosed a score of 12/15 (Moderate cognitive impairment). A review of R143's care plan revealed the following: Focus: (R143) is at risk for impaired skin integrity/pressure injury R/T (related to): GSW (gunshot wound), generalized weakness, impaired mobility, and incontinent of bowel and bladder. Date Initiated: 01/30/2025 . Interventions: Follow facility policies/protocols for the prevention/treatment of impaired skin integrity. Date Initiated: 01/30/2025 . Focus: R143 has Actual impairment to skin integrity r/t pressure injury to sacro-coccyx Date Initiated: 01/30/2025 . (continued on next page)

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	05/13/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/25 at 10:38 AM, R143 was observed in bed, on their left side watching TV. Wound Care Nurse AA applied a pair of gloves and untaped R143's brief, pulled the brief slightly down to view the wound. The wound was located at the sacrum, stage three pressure ulcer, with a small amount of serosanguineous drainage. The wound bed was pink and without odor. Wound Care Nurse AA removed R143's wound dressing. Wound Care Nurse AA removed their gloves and donned a clean pair of gloves without sanitizing their hands. Wound Care Nurse AA performed wound care and applied R143's dressing. Wound Care Nurse AA was informed that they did not perform hand hygiene for R121 and R143 after removing their contaminated gloves and donning clean gloves. Wound Care Nurse AA stated, Ok. No additional explanation was provided. On 05/12/25 at 12:25 PM, the Director of Nursing (DON) was interviewed and was queried about Wound Care Nurse AA not performing hand hygiene prior to donning clean gloves for R121 and R143. The DON stated, Staff will be re-educated. A review of the facility's policy Hand Hygiene dated 10/11/2023 revealed the following: To decrease the risk of transmission of infection by appropriate hand hygiene. Hand washing/hygiene is generally considered the most imported single procedure for preventing healthcare-associated infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inanimate objects. A Policy for PICC lines was requested was requested from the DON at the time of interview with the DON. The DON said the facility did not have a policy on PICC lines. The DON provided a copy of a document titled Peripherally Inserted Central Catheter (PICC) flushing and locking with a revision date of 8-19-2024. The document stated when locking a locking device place an end cap on the connector to reduce the risk of vascular associated infections.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 Based on interview and record review, the facility failed to administer the Pneumococcal and Influenza vaccines to one resident (R10) of five residents reviewed for infection control resulting in the likelihood for increased risk for acquiring, transmitting and experiencing complications from the pneumonia and the flu. Findings Include: On 5/12/25 at 10:20 AM, the Infection Control Program was reviewed with the Infection Control Registered Nurse (RN) A. RN A was provided a list of residents to be reviewed for vaccinations. RN A provided documentation that R10 did sign to receive the Pneumococcal and Influenza vaccinations on 8/8/2024. There was no documentation that R10 had received either the Pneumococcal or Influenza vaccinations. RN A said she was unable to find the documentation that the vaccination was administered in the vaccination book or in the electronic medical record (EMR). 05/13/25 10:15 AM, the Director of Nursing (DON) was interviewed and acknowledged that there was no documentation that R10 had received the Pneumococcal and Influenza vaccines that the R10 had signed for on 8/8/25. The DON said her expectation is that when residents are offered vaccinations, they sign the consents that the medication would be administered. Record review revealed R10 was initially admitted on [DATE]. R10 admitting diagnosis was for Acute Cerebral Insufficiency (stroke), Chronic Obstructive Pulmonary Disease, Hypertension, Generalized Anxiety, Major Depressive Disorder, Dysphagia and Aphasia. Review of R10 Minimum Data Set Quarterly Review dated for 2-14-2025 for Brief Interview for Mental Status showed that R10 was severely cognitively impaired with a score of 0 out of 15. Record review of document titled Immunizations: Pneumococcal Vaccination (PPV) of Residents last revised 11-4-2024 noted, all residents over the age of 65 should receive the Pneumococcal vaccination. The vaccination is recommended for individuals younger than 65 if they have underlying conditions that increase the risk for serious disease and its complications. Prior to administration of the medication informed consent will be obtained. The resident will be informed of the risk and of the vaccination. If signed consent was required by state law, it would occur during the information step. The administration of the vaccination will be documented in the following manner. The administration and injection site for the medication will be documented in the medical record. The immunization information should be submitted to state entity as required. On 5/13/2025 at 9:58 AM, request was made to the Nursing Home Administrator for influenza vaccination policy, but not received by exit of survey.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record review the facility failed to ensure functional equipment in a safe and sanitary manner, resulting in broken equipment and an unsanitary environment. This deficient practice had the potential to affect 143 of 146 residents in the facility. Findings include: On 5/6/25 at 12:11pm during a meal observation residents: R70, R71, R22, and R26 were observed in wheelchairs with torn and ragged arm rests. On 5/7/25 at approximately 2:00PM resident 67 was also observed with a wheelchair the arm rests were torn, ragged and uneven. On 5/7/25 at 11:40 AM during an observation of the walk-in freezer approximately 5-6 missing floor tiles created an indentation at the threshold of the door. There was no excursion around the bottom section of the freezer door causing a visible gap from the inside and safety concerns when entering and exiting the freezer door because of ice accumulation. During an observation of delivery of goods to the facility on [DATE] at approximately 11:50 A.M. the delivery staff had to ask DMN for facility's assistance to place delivery in the walk in freezer. Both men had to literally lift the cart over the broken tile area. Dietary Manager (DM) N was asked how long the threshold had been missing. (DM) N responded over a year. Maintenance Manager S who was present during the observation reported the facility was in the process of repairing the threshold and a requisition could be provided. There was also a double-deck non-functional South Bend steamer noted. Maintenance Manager S stated a used Mother Board was being searched for as a replacement for the steamer. In the dish room in the 3 compartment sink a broken leaking faucet caused water to overflow the sink. On the first and second floors of the nourishment rooms were soiled and littered with paper and debris. In the nourishment room on the first floor the perimeter of the sink had cracked floor tiles which created an uneven surface. In the second-floor nourishment room on the [NAME] wall the bottom panel had an open hole in the wall, measuring approximately 6X6 inches which was covered by a garbage can. (DM) N was interviewed during the observation of the kitchen and the nourishment rooms and indicated the nourishment room was monitored 3 times a day by dietary staff, but the cleaning was performed by the housekeeping department. On 5/12/25 at 3:15 P.M. Maintenance Manager S was reminded to submit the requested documents regarding the broken kitchen equipment and the safety concerns in the nourishment rooms to the Administrator. Upon the exit from the facility on 5/13/25 at approximately 3:30 PM the documents requested by the surveyor were not submitted. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of 2017 US Public Health Service Food Code, Chapter 4-601. 11 Food contact surfaces and non-food contact surfaces and utensils directs, (C) non-contact surfaces of equipment should be kept free of accumulation of dust, dirt, and food residue and other debris.