STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235452	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Heights-Detroit	19100 West Seven Mile Road Detroit, MI 48219

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI00141524. Based on interview and record review, the facility failed to thoroughly investigate an injury of unknown origin and unexpected death for one (R162) of two resident reviewed for abuse. Findings include: The State agency received a complaint that R162 was found expired in her room on the floor with an injury of unknown origin to the back of her head. A review of R162's closed Electronic Health Record (EHR) revealed that on [DATE] at approximately 7:45 AM the resident was observed laying on her left side on the floor in front of her bed and determined to be expired. There was no additional progress note or total body assessment that documented the condition of the resident's head or body. R162 was receiving palliative care (medical care focusing on pain relief) and had a 'Do Not Resuscitate' order. There was no Accident and Incident (A&I) report for [DATE] in the resident's EHR. On [DATE] at 11:22 AM the facility's 'Safety Coordinator' Licensed Practical Nurse (LPN) H was asked about R162's incident on [DATE]. LPN H said there was no A&I report or further documentation because the resident had expired. LPN H acknowledged that R162 was found on the floor and said, There was no A&I report to indicate that a fall occurred. So we don't know what happened. LPN H could not say with certainty if R162 had an injury to the back of her head. On [DATE] at 11:33 AM the Director of Nursing (DON) was asked about R162 being found deceased on the floor on [DATE]. The DON acknowledged that no investigation or A&I report had been documented. The DON said she had interviewed both the nurse and the CNA (certified nursing assistant) that day and started an investigation regarding R162' death, but there was no documentation to support that. The DON said, An investigation should have been completed for the resident (R162). It is in the facility policy. The DON could not say with certainty if R162 had an injury to the back of her head. At 2:15 PM the DON said she conducted a late investigation and made a late entry in R162's closed EHR. According to the facility's Abuse Prohibition Policy last revised on [DATE], in part: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative. Definition: Adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. Injuries of unknown source - An injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the guest/resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the extent of the injury, or the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time or the incidence of injuries over time.