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	05/30/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to properly maintain residents' wheelchairs for two residents (R34 and R86), out of six residents reviewed for a safe and comfortable environment, resulting in resident discomfort and potential for the spread of harmful pathogens. Findings include: On 5/27/25 at 10:19 AM, R34 was observed asleep in bed. Both armrests of the wheelchair observed in R34's room were in disrepair. The covering on one armrest was severely frayed and only partially covered the foam underneath. There was no padding or covering on the other armrest which would result in the resident's arm positioned on bare metal. The covering on the back section of R34's wheelchair was partially missing exposing the foam underneath. On 5/27/25 at 12:51 PM, R86 was observed awake in her room sitting in a wheelchair. The covering on both armrests on R86's wheelchair were split and frayed, and the padding underneath was exposed. R86 said sometimes the armrests hurt her arms. On 5/30/25 at 10:41 AM, Therapy Manager (TM) F said managers do rounds on the residents and were to contact maintenance if a resident's wheelchair required repair. TM F stated, We have (wheelchair arm) replacement pads available. TM F added damaged wheelchair armrest pads should be replaced because it's more comfortable for the patient and the look is more appropriate. After observing R34 sitting in his wheelchair, TM F said one armrest was missing a cushion, the other armrest was worn out and needed to be replaced, and the back support was torn and needed to be replaced. After observing R86's wheelchair, TM F said both armrests were torn and did not have a smooth, solid surface. A review of the clinical record for R34 documented an initial admitted [DATE] and readmitted [DATE]. R34's diagnoses included osteoarthritis, muscle wasting, difficulty in walking, and dementia. A Minimum Data Set (MDS) assessment dated [DATE] documented severe cognitive impairment and the use of a wheelchair for mobility. A review of the clinical record for R86 documented an initial admitted [DATE] and readmitted [DATE]. R86's diagnoses included atrial fibrillation, hemiplegia and hemiparesis affecting right dominant side, and difficulty in walking. A MDS assessment dated [DATE] documented intact cognition and the use of a wheelchair for mobility. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/25 at 1:31 PM, the Director of Nursing (DON) said the condition of R34's and R86's wheelchairs should have been seen by nursing and reported to maintenance for replacement. The cracked surface of the wheelchair armrest could cause bruising of the resident's skin. The DON added that it was an infection control issue because the cracked surface of the armrest could not be truly cleaned if exposed to bodily fluid. On 5/30/25 at 3:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information pertaining to this citation when asked.

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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. 22349 Based on observation, interview, and record review, the facility failed to ensure that medications were administered in accordance to professional standards of practice for two (R12 and R17) of five residents reviewed for medication administration resulting in the potential for medication errors to occur. Findings include: On 5/28/25 at 8:28 AM Licensed Practical Nurse (LPN) C was observed to have two medications cups with pills inside stacked on top of each other on the medication cart. During inquiry LPN C said the medications were for two different residents, R12 and R17. R12's medication cup was on the top and R12's medication cup was underneath. LPN C said they were going to administer the medications to the residents and then sign them out because, It saves time to pull two resident's medications at the same time. Upon inspection of the medication cups it was determined that neither R12 or R17 had their entire 9:00 AM prescribed medications in the medication cups. LPN C said, I only put the packaged medications in the cups. Not the floor stock medications. LPN C acknowledged that this was not the standards of practice for medication administration and did not align with the facility's medications administration policy. At this time nurse manager, LPN B was present and asked about medication administration. LPN B replied, We should only pull one resident's medications at a time, administer the medication to that resident, and then sign the medications out. I don't know what is going on here. Observation of the medication cup identified to be for R12 revealed the following 8 pills in the cup: 1- folic acid 5 milligrams (mg) 5 tablets of 1 mg each 2- carbamazepine 200 mg 2 tablets 3- norco 5-325 mg 1 tablet According to the physician's orders and Medication Administration Record (MAR) the following medications were also prescribed for the 9:00 AM and not in R12's medication cup or prepared for administration: - aspirin 81 mg - calcium carbonate 600 mg - lactulose 30 milliliters (ml) - magnesium hydroxide 30 ml - artificial tears 1- 0.3% 1 drop each eye (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the medication cup identified to be for R17 revealed the following 7 pills in the cup: 1- tamsulosin 0.4 milligrams (mg) 1 capsule 2- chlorthalidone 25 mg 1 tablet 3- farxiga 5 mg 1 tab 4- hydralazine 50 mg 2 tabs 5- metformin 1000 mg 1 caplet 6- xanax .5 mg 1 tablet According to the physician's orders and Medication Administration Record (MAR) the following medication was also prescribed for the 9:00 AM and not in R17's medication cup; - aspirin chewable 81 mg 1 tablet On 5/27/25 at approximately 11:00 AM during an interview the Director of Nursing (DON) said, The nurse should prepare one resident's medication at a time. After administering those medications to that resident then sign them out. I don't know why someone would pull multiple resident's medications at the same time. It's not safe and doesn't follow the standards of practice. According to the facility's Medication Administration policy last revised on 10/17/2023 in part read: Residents medications are administered in an accurate, safe, timely, and sanitary manner. 4. Follow safe preparation practices. a- prepare medications immediately prior to administration.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38207 Based on observation, interview, and record review the facility failed to ensure that nail care was provided for one dependent resident (R107) of three reviewed for activities of daily living care (ADLs). Findings include: On 5/27/25 at 10:51 AM, 5/28/25 at 1:40 PM, and 5/29/25 at 12:14 PM, observations were made of R107's nails being one forth to one third of an inch above the tip of their thumb and multiple fingers. R107's nails were observed to be discolored with a light brownish appearance. R107 was interviewed multiple times about the length and appearance of their nails and did not respond to the surveyor's questions. On 5/29/25 at 12:16 PM, certified nurse assistant (CNA) A was interviewd and shown R107's nails. CNA A indicated that they needed to be trimmed and cleaned. On 5/29/25 at 12:31 PM, unit nurse manager/licensed practical nurse (UNM/LPN) B was interviewed about their expectations regarding nail care involving R107. UNM B indicated that they had noticed the condition of R107's nails yesterday and that the nurse working yesterday should have taken care of them. A review of R107's electronic medical record (EMR) under the Task section for the past thirty days of R107's ADL care revealed documentation which indicated that routine care was provided for the resident on a daily basis, including .Nail care. A review of R107's behavior for the past thirty days involving, Behavior Monitoring: resistant to care combative, grabbing revealed, twenty six out of thirty days which were documented as, None of the above observed and three days documented as, Not applicable. A further review of R107's EMR revealed that R107 was most recently admitted to the facility on [DATE] with diagnoses that included Dementia and Protein-calorie malnutrition. R107's most recent quarterly minimum data set assessment (MDS) dated [DATE] revealed that R107 had a severely impaired cognition and required maximum assistance to being totally dependent for their ADLs. On 5/29/25 at 1:29 PM, the Administrator (NHA) was interviewed regarding their expectations for nail care involving dependent residents. The NHA indicated that residents' nails should be cleaned and trimmed as needed. Refusals and/or resistance to care should be documented. A facility policy titled, Activities of Daily Living (ADL) Program Last Revised: 4/5/2024 stated the following, Purpose: ADL[s] may include, but are not limited to .grooming .Procedure: .A resident may benefit from [an] . ADL Program if .g. Residents who require extensive assistance with grooming .3. Determine specific tasks and areas of ADLs .Grooming may include x. Trimming nails.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on interview and record review the facility failed to ensure a physician ordered lab draw (Keppra level) was completed for one resident (R84) reviewed for lab results, resulting in R84's physician being unaware that the ordered Keppra level was not completed along with the potential for an abnormal Keppra blood level go undetected and untreated. Findings include: Review of R84's Electronic Health Record (EHR) revealed the resident readmitted to the facility on [DATE] with multiple diagnoses that included Chronic Kidney disease and Epilepsy (seizures). According to the physician's orders on 4/11/25, R84 was prescribed Keppra 750 milligrams (mg) twice a day. On 4/24/25, R84 was ordered to have a Keppra blood level drawn. As of 5/27/25 there was no Keppra level results available and no progress notes to indicate a Keppra level had been drawn. Further review of R84's EHR revealed the resident had no seizure activity in the facility. On 5/27/25 at approximately 1:00 PM the Director of Nursing (DON) reviewed R84's EHR and said, It looks like the Keppra level was not drawn. I will reach out to the lab to determine where the Keppra level is. On 5/29/25 at 10:27 AM the DON said the Keppra level was not drawn by lab because the nurse did not put the order in correctly. The DON added the Medical Director will be notified and the Keppra level would be drawn immediately. The DON was asked for a policy for labs and said, We don't have a policy for labs or blood draws, but we do have one for following physician's orders. The Keppra level should have been done and followed up with by now. According to Drugs.com; Keppra (levetiracetam) is an anticonvulsant/antiseizure drug. Optimal response (therapeutic range) for levetiracetam is achieved with blood serum levels of 10.0 - 40.0 micrograms/milliliter (mcg/ml). According to Labtestsonline.org; Keppra (levetiracetam) does not require routine periodic monitoring, but levetiracetam test may be requested and reviewed to adjust the dosage as necessary. Review of the facility's Physician's Order policy last revised on 10/20/2023 in part reads; Physician orders are obtained to provide 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 the a physician .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34901 Based on observation, interview, and record review, the facility failed to ensure an adequate supply of emergency food was available. Findings include: On 5/29/25 at 11:16 AM, an observation and interview regarding the facility's emergency food supply was conducted with Dietary Manager (DM) H. DM H provided a document titled, Emergency Planning Recommendations for your Facility which indicated in part the following: We suggest storing a minimum of a 3-day supply of non-perishable food on site. DM H agreed that non-perishable foods were shelf-stable (food stored at room temperature and able to last long periods without spoiling). This document included a disaster menu for Day 1, Day 2, and Day 3. The disaster menus for Day 1, Day 2, and Day 3 were compared to the shelf-stable food on hand. The following items were not available and not substitutable with other foods on hand: assorted 100% juices, high protein breakfast bars, shelf-stable milk, and canned potatoes. The following shelf-stable food items listed on the disaster menus were also not available but may, in an emergency, be substituted with other items that were on hand: green beans, chicken and dumplings, carrots, apricots, ham, green peas, pulled chicken, mixed vegetables, assorted sodas, and stewed tomatoes. On 5/30/25 at 1:56 PM, the Nursing Home Administrator (NHA) stated, We should have the correct amount of food for three days. In the future we will make sure we have what is exactly on the menu. On 5/30/25 at 3:00 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information pertaining to this citation when asked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34901 Based on observation, interview, and record review, the facility failed to: 1. Ensure proper cooling of cooked, potentially hazardous (time-temperature for safety) food, meatballs, corned beef, baked beans, and diced potatoes; 2. Ensure the caulking of the hand washing sink was in good repair; 3. Store an ice scoop in a clean and sanitary manner; and 4. Properly date-label food stored in a resident refrigerator. These deficient practices resulted in the potential for food-borne illness for the residents that eat from the kitchen and residents that reside on the first-floor unit. Findings include: On 5/27/25 at 8:36 AM, the initial tour of the kitchen began with Dietary Manager (DM) H. The following was observed inside of the walk-in cooler: a pan of previously cooked meatballs dated 5/24, a pan of previously cooked corned beef dated 5/26, a pan of previously cooked baked beans dated 5/26, and a pan of previously cook diced potatoes dated 5/26. DM H said staff did not complete a cooling log for these previously cooked food items. On 5/28/25 at 12:39 PM, Certified Nurse Aide (CNA) J was observed passing ice water to residents on the first floor. CNA J was observed reaching into a portable ice chest, pulling out a scoop full of ice, putting the ice in a cup, and placing the ice scoop back in the chest with the ice. CNA J was not wearing gloves. When queried if the ice scoop should be stored inside the ice chest, CNA J said, I should have stuck it in the bin (located outside of the ice chest) to avoid contamination (of the ice). On 5/29/25 at 11:16 AM during a return visit to the kitchen, DM H said the cooks were responsible for storing previously cooked food in the cooler and were unaware of the correct procedures to cool cooked food. The caulking around the handwashing sink was observed to be missing. DM H stated, If water gets behind (the sink) bacteria could grow. When asked about the proper storage of an ice scoop, DM H said cross contamination could occur when you place the ice scoop handle on the ice. On 5/29/25 at 11:30 AM, the contents of the 1st floor resident's refrigerator were observed with DM H. The following items stored in the refrigerator were not identified with a resident's name: a disposable container of partially eaten stir fry, a 16.9 oz. bottle of carbonated beverage, an opened loaf of bread, an opened pack of sliced salami, an opened pack of sliced American cheese, and a disposable container of salad. A review of the policy titled, Food from Outside Sources, dated 11/12/21, documented in part the following: All food brought in is to be checked by the Nurse, Dietary Manager, or Dietitian. It must be placed in a sealed container and labeled for the content, the guest's/resident's name and date the food was received, and an expiration date of 3 days after food was brought in. It is recommended that only enough food be brought in for that visit. According to the 2013 FDA Food Code: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Section 3-101.11, Safe, Unadulterated, and Honestly Presented, was reviewed and revealed, Food shall be safe, unadulterated, and, as specified under S 3-601.12, honestly presented. Section 3-304.12 In-Use Utensils, Between-Use Storage. During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: (E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not time/temperature control for safety food. Section 3-501.14, Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 135 F to 70 F; and (2) Within a total of 6 hours from 135 F to 41 F or less. Section 4-501.11, Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. On 5/30/25 at 3:00 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information pertaining to this citation when asked.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on interview and record review the facility failed to accurately document one resident's (R93) code status in the electronic medical record (EMR) out of six residents reviewed for advanced medical directives (AMD), resulting in the potential for R93's choices not being followed. Findings include: Record review of R93's information page in the EMR documented in the code status area that resident was a Full Code (resuscitation would be performed in the event resident had no heartbeat or breathing had stopped). Record review of R93's Do-Not-Resuscitate Order revealed, I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order will remain in effect until it is revoked as provided by law. Being of sound mind, I voluntarily execute this order, and I understand its full import. Further review of form revealed resident had signed the document on 7/8/24, as well as R93's attending physician. An interview was conducted on 5/27/25 at 11:10 PM with R93, it was confirmed that the resident was a DNR (Do not resuscitate). Review of R93's EMR revealed admission into the facility on [DATE] with a pertinent diagnosis of a history of myocardial infarction (heart attack). Review of R93's Brief Interview for Mental Status (BIMS) dated 4/11/25, R93 scored 15 out of 15 (intact cognition). Review of Physician Orders dated 2/19/25 documented resident was a full code. Review of Physician Progress Notes dated 5/20/25, 4/22/25, 2/4/25, 12/24/24 documented CODE STATUS-DNR. An interview was conducted on 5/29/25 at 10:04 AM with Licensed Practical Nurse (LPN) K, it was reported in the event a resident had no heartbeat and breathing had stopped, LPN K would refer to the resident's information page under code status to confirm if resuscitation should be performed before proceeding forward with care. An interview was conducted on 5/29/25 at 10:20 AM with LPN C, it was reported in the event a resident had no heartbeat and breathing had stopped, LPN C would refer to the resident's information page under code status to confirm if resuscitation should be performed before proceeding forward with care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/29/25 at 10:22 AM with Unit Manager (UM) L, It was reported in the event a resident had no heartbeat and breathing had stopped the nursing staff should refer to the resident's information page and under code status before proceeding with care. It was further reported that R93's code status was changed when the resident had returned from a hospital stay on 2/19/25 in error, and the resident should have not been changed to a full code and remained a DNR per the resident's wishes. An interview was conducted on 5/29/25 at 12:12 PM with the Director of Nursing (DON), it was reported that nursing should consult the special instructions (information page) before proceeding with care. It was further reported that R93's EMR was marked inaccurately and R93 should have remained a DNR after returning to the facility on [DATE]. The facility's policy Advance Directive-Michigan dated 7/6/23 documented, . A. Recognition of Resident Self-Determination. The Facility is committed to the promotion of the well-being of all our Residents. We recognize each Resident's right to refuse treatment, to live a dignified life, and to self-determination, which includes the right to refuse care and to formulate advance directives regarding future care.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 34901 Based on observation, interview, and record review, the facility failed to ensure consistent proper working order of the facility's walk-in freezer which had the potential to affect all residents that eat from the kitchen. Findings include: During the initial tour of the kitchen on 5/27/25 at 8:36 AM with Dietary Manager (DM) H, the internal temperature of the walk-in freezer was observed to be 9 F (Fahrenheit). A four-ounce cup of ice cream stored in the freezer was observed soft, not frozen solid. During a return visit to the kitchen on 5/29/25 at 11:16 AM with DM H present, the internal temperature of the walk-in freezer was 9 F. A four-ounce cup of ice cream stored in the freezer was soft, not frozen solid. The walk-in freezer door did not seal properly when closed. A noticeable gap was visible when the freezer door was closed which allowed cold air to escape. DM H stated, I never considered it (the freezer door not closing properly) being a concern because the meat was always frozen. We need to shop for a new freezer. On 5/30/25 at 1:56 PM during an interview, the Nursing Home Administrator (NHA) said they knew the freezer door needed to be replaced but had not started the process prior to this survey. A review of the 2013 FDA Food Code revealed the following: - Section 3-501.11. Stored frozen foods shall be maintained frozen. - Section 4-501.11. Food repair and proper adjustment. (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) Equipment components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. On 5/30/25 at 3:00 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information pertaining to this citation when asked.