Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235545	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Whitmore Lake	8633 N Main St Whitmore Lake, MI 48189

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 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** 32568 This citation pertains to Intake Number(s): MI00144739 Based on observation, interview, and record review, the facility failed to ensure care and supervision was provided based on professional standards of practice for one (R802) of eight residents reviewed . This had the potential to affect all 21 residents who resided on Unit 3 on 5/26/24. Findings include: A review of a complaint submitted to the State Agency revealed, Upon entering unit 3, there was no staff in sight. A chair with the company's computer was open but no one available. As we continued into the common area, there was a nurse aide playing trivia with the residents .After speaking to the one aide we went to a different unit looking for help and she found a second aide cleaning in the room and confirmed the main nurse was still on break and only the 2 aides were present in Unit 3 .While no staff on site there is resident with soiled pants, one resident behind the nurses station trying to use the phone and two others about to fall and trying to escape the floor .This is a formal complaint of concern that the nurse still hasn't returned in over 30 minutes, our grandmother life is endangered with .lack of supervision for her and all residents and in overall concern of safety, health and well being . On 6/3/24 at 2:35 PM, an observation of Unit 3 was conducted. Unit 3 was a locked unit where residents who had cognitive impairment resided. On 6/4/24 at 9:10 AM, the complainant was interviewed via the telephone. The complainant reported they arrived to the facility on [DATE] around 3:30 PM to return R802 after an overnight leave of absence (LOA). According to the complainant, there was nobody visible on the unit except an activity aide who was in the day room with residents. The complainant reported she had R802's medications that were sent with her on LOA, but there was no nurse to give them to. The complainant reported she found a Certified Nursing Assistant (CNA) from another unit who offered to take the medications, but the complainant was not comfortable with that because she was a CNA and not a nurse. The complainant reported the pharmacy arrived to the unit to deliver medications, but there was no nurse available. The pharmacy staff left the unit and a CNA returned to Unit 3 with medications which she placed behind the nurses station which was located inside of the day room. The complainant was concerned due to the absence of a nurse on the unit and no CNA visible in the hallway or in the day room and residents were standing up unassisted, attempted to get out of the door to the unit, and went behind the nurses station desk. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R802's clinical record revealed R802 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Alzheimer's Disease. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had severely impaired cognition; behaviors that included physical, verbal, rejection of care, and wandering; and had two or more falls since previous assessment, including one fall with an injury. A review of R802's incident reports for the past three months revealed R802 had fallen 10 times. A review of a Guest/Resident, Family, Employee, and Visitor Assistance Form completed by R802's family member, revealed the family member was concerned on 5/26/24 at from approximately 3:30 PM to 4:40 PM there was No nurse on unit when came to drop mom off .Difficulty finding CNA staff on unit/only activities . The Administrator reported that the grievance was in the process of being investigated by the Director of Nursing (DON). A review of staff assigned to Unit 3 on 5/26/24 between 3:30 PM and 4:30 PM revealed Registered Nurse (RN) 'F' was the nurse assigned to that unit, and CNA 'K' and CNA 'M' were the assigned CNAs for that unit. Activities Aide 'P' provided activities to Unit 3 on 5/26/24. On 6/4/24 at 10:30 AM, an interview was conducted via the telephone with CNA 'K'. CNA 'K' was assigned to Unit 3 on 5/26/24. When queried about what occurred on 5/26/24, CNA 'K' reported RN 'F' went on break around 3:30 PM. After RN 'F' left the unit, CNA 'K' left the unit and went to Unit 1 to let a nurse know she was leaving at 7:00PM. CNA 'M' remained on the unit, in addition to Activities Aide 'P' who was in the day room. When CNA 'K' arrived back to Unit 3, R802's family was there returning R802 from a LOA and they were upset that there was no nurse or CNA visible on the unit. CNA 'K' informed the family that RN 'F' would return from break in about 10 to 15 minutes, but she did not return for an hour. CNA 'K' reported R802's family was upset because they felt R802 and the other residents needed more supervision and she had R802's medications to return to the nurse. R802 was in the day room and attempting to get out of the wheelchair and family had to assist. CNA 'K' reported she received disciplinary action because she did not attempt to get assistance from another nurse in the building. On 6/4/24 at 12:35 PM, an interview was conducted via the telephone with RN 'F'. RN 'F' confirmed she worked on Unit 3 on 5/26/24. When queried about what occurred that afternoon, RN 'F' explained it was a hectic day with an unusual amount of behavioral activity from the residents. RN 'F' stated, This day the residents were really high strung starting first thing in the morning. RN 'F' further reported that she took a lunch break which was 30 minutes and combined it with two 15 minute breaks around 3:30 PM. RN 'F' explained that due to how busy the unit was that day, that was the first time she had a chance to take a break. When queried about coverage for Unit 3 when she was on break, RN 'F' reported she told CNA 'K' and CNA 'M' that she was going on break. RN 'F' did not inform another nurse in the building. RN 'F' explained that she took her break in her vehicle located in the facility parking lot and since she did not leave the premises she did not have to inform a nurse or punch out. RN 'F' had the keys to the medication cart during her break. RN 'F' reported that when she returned from her break, CNA 'M' was on the unit and CNA 'K' went to another unit. R802's family members were there and very upset because of the lack of supervision on the unit and that there was not a nurse to give R802's medications to. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 1:45 PM, an interview was conducted with the DON. When queried about the facility's protocols for nursing staff when they took a break, the DON reported if it was a 15 minute break or leaving the unit for a moment to get supplies, the nurse was to inform the CNAs. If the nurse took a regular 30 minute lunch break in the break room within the facility, the CNAs were informed and instructed to stay on the unit and to page the nurse if needed. If the nurse was not inside the building where they could hear a page, then report was given to another nurse to cover the unit and the keys to the medication cart were given to the covering nurse. The DON reported RN 'F' did not follow the protocol to ensure continuity of care during an extended break outside of the facility on 5/26/24. The DON further explained that CNA 'K' should have stayed on the unit and paged a nurse to come to the unit to address R802's family's concerns.

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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** 32568 This citation pertains to Intake Number(s): MI00144739 and MI00133567. Based on interview and record review the facility failed to monitor blood pressures to ensure medications were administered according to physician ordered parameters for one (R802) of two residents reviewed for medications. Findings include: A review of two complaints submitted to the State Agency alleged residents' medications were not properly administered. A review of R802's clinical record revealed R802 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertension (HTN). A review of R802's Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had severely impaired cognition. A review of R802's active Physician's Orders revealed an order dated 5/18/24 for amlodipine 5 milligrams (mg) two tablets one time a day (upon rising) with instructions to hold the medication if systolic blood pressure (top number) was less than 100 mmhg (millimeters of mercury). A review of R802's Medication Administration Record (MAR) for May 2024 and June 2024 revealed no documentation of R802's blood pressure to indicate whether the amlodipine should be given or held. It was documented R802 received the medication daily since 5/18/24. On 6/3/24 at approximately 1:48 PM, a review of R802's Blood Pressure Summary revealed no documented blood pressures on 5/20/24, 5/21/24, 5/24/24, 5/25/24, 5/27/24, 5/29/24, 5/30/24, 5/31/2, 6/1/24, 6/2/24, and 6/3/24. On 6/4/24 at 10:14 AM, an interview was conducted with the Director of Nursing (DON). The DON reported if a blood pressure medication had parameters, the resident's blood pressure should be documented on the MAR at the time of administration or in the blood pressure summary. On 6/4/24 at approximately 1:45 PM, the DON reported she did not see R802's blood pressures consistently documented in the clinical record and the order was not entered properly to ensure documentation and monitoring of blood pressure before administration of the amlodipine. A review of R802's care plans revealed, (R802) is at risk for cardiac complications r/t (related to) HTN . Interventions included: Vital Signs as ordered and Administer medications per order. A review of a facility policy titled, Medication Administration, revised on 10/17/23, revealed, in part, the following: .If applicable and/or prescribed, take vital signs .prior to administration of the dose .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32568 This citation pertains to Intake Number(s): MI00144739. Based on observation, interview, and record review, the facility failed to implement effective interventions to prevent repeated falls for one (R802) of three residents reviewed for accidents and supervision. Findings include: A complaint was submitted to the State Agency that alleged there was a lack of supervision on Unit 3 and residents were at risk of falling. On 6/3/24 at 2:35 PM, an observation of Unit 3 was conducted. Unit 3 was a locked unit and residents with impaired cognition resided on that unit. Upon entrance to the unit, Certified Nursing Assistant (CNA) 'O' was observed in the hallway and Registered Nurse (RN) 'E' was seated behind the desk in the day room. No staff were interacting with the residents. R802 was observed seated at a table alone facing away from the television and sleeping in her wheelchair. Another resident was facing the doorway falling asleep at the table with her head pressed against the table. On 6/3/24 at 3:23 PM, R802 was observed sleeping in the wheelchair in the day room. RN 'E' was behind the desk. No CNAs were observed in the room at that time. On 6/4/24 at 10:21 AM, R802 was seated at a table in the day room. R802 was observed pushing against the table. The wheelchair was locked. At that time, R802 told CNA 'N' that she had to use the bathroom. CNA 'N' took R802 to the toilet in the shower room located on Unit 3, exited the shower room and left R802 in there, and sat down in the day room. RN 'E' whispered to CNA 'N' and CNA 'N' then reentered the shower room to supervise R802. On 6/4/24 at 2:17 PM, multiple residents were observed seated in the day room. RN 'E' and two CNAs were observed in the room, but were not interacting with the residents. On 6/5/24 at 9:15 AM, R802 was observed seated at a table with a breakfast tray. CNA 'J' was observed having a personal conversation with Licensed Practical Nurse (LPN) 'I'. CNA 'J's back was to the residents. R802 was observed trying to drink a nutritional juice that was in a paper carton, but the carton appeared sealed and the resident was unable to drink from it. There was no interaction with the residents until the surveyor entered the day room. On 6/5/24 at 10:16 AM, R802 was seated at a table alone. LPN 'I', CNA 'J', and another CNA were observed having a personal conversation about exercising. The staff were not interacting with the residents in the day room. When the staff noticed the surveyor, CNA 'J' and the other CNA went to the hallway. CNA 'J' reported there was a resident who was trying to exit the unit. Multiple residents were in the day room without an activity or engagement from staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R802's clinical record revealed R802 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Alzheimer's Disease. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had severely impaired cognition; behaviors that included verbal, physical, rejection of care, and wandering; and had two or more falls since the previous assessment with no injury and one fall with an injury. A review of R802's progress notes, incident reports, and post fall evaluations since March 2024 revealed R802 had fallen 10 times, including multiple times while in the day room. The documented falls and interventions were as follows: 1. On 3/15/24 at 6:49 PM, R802 fell in the day room witnessed by staff. R802 was moving chairs around, was asked to stop, but kept moving the chairs and tripped and fell on to her side. The new intervention to prevent future falls was to assist/redirect the resident when moving small furniture and chairs, provide diversional activities, and assist to rest in room. 2. On 3/23/24 at 1:15 AM, R802 stood up and started to move the chairs in the day room and fell . R802 sustained a bruise to the left eye and a bump on her head. It was documented R802 had a history of moving chairs. According to the post fall evaluation, the new intervention implemented was a medication adjustment to address anxiety, pain, and blood pressure. It did not address looking into why R802 liked to move the furniture or what could be done to deter her from that. 3. On 4/15/24 at 3:40 PM, R802 fell in the hallway by the exit door and hit her head. It was recommended that a chair be places by the exit door so she could rest if needed. It should be noted that a chair was not observed by the exit door on 6/3/24, 6/4/24, and 6/5/24. 4. On 4/23/24 at 2:00 PM, R802 fell in her room and it was documented she was sitting on the floor brushing her hair. It was noted that R802 had a history of placing self on floor. R802 as taken to the day room for observation. 5. On 4/23/24 at 5:00 PM, three hours after the previous fall which resulted in R802 being brought to the day room for supervision, R802 fell in the day room and was observed between the outer wall and dining room table with her wheelchair tilted toward her legs. R802 complained of head pain and was sent to the hospital for evaluation. Upon return to the facility, the new intervention to prevent future falls according to the post fall evaluation was a medication review and laboratory review. 6. On 5/4/24 at 2:46 AM, R802 was observed lying on her back in the hallway without a wheelchair or cane. It was documented R802 had been wandering and was last observed five minutes prior to incident. The new intervention to prevent further falls was for the nurse practitioner to continue to monitor resident after a medication change. 7. On 5/9/24 at 4:56 PM, R802 fell in the day room after she stood up from the table. R802 fell into the wall and slid to the floor. The new intervention to prevent further falls was to have R802 seated next to activity aide during activities. 8. On 5/14/24 at 3:09 PM, R802 was standing by a table in the dayroom with a hairbrush and lost balance and fell , hitting her head on another resident's walker. R802 was sent to the hospital for evaluation. The new intervention was to provide the resident with a weighted doll to decrease restlessness and provide diversional activity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 5/14/24 at 11:03 PM, R802 got out of bed unassisted and fell in the hallway. 10. On 5/28/24 at 8:30 AM, R802 was found on the floor in her room, laying on her back by the doorway to the bathroom without a gown or brief on. R802 was incontinent. Further review of the post fall evaluations revealed there was no in-depth analysis of what was in place for R802 at the time of the falls. On 6/5/24 at 10:33 AM, an interview was conducted with the Director of Nursing (DON). When queried about what has been done to find the root cause of R802's falls, the DON reported they have looked at multiple things such as medication side effects, psychiatric symptoms, and whether she was experiencing more dementia symptoms at night. When queried about what had been done to evaluate the staffing needs or whether staff were implementing the interventions in the day room, the DON did not offer a response. Observations made on 6/3/24, 6/4/24, and 6/5/24 were shared with the DON who reported more engagement and interaction with the residents on Unit 3 could prevent falls and they needed to look into that. A review of a facility policy titled, Fall Management, revised 9/22/23, revealed, in part, the following: The facility will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls .Residents identified at risk for falls will have an initial plan of care developed to meet each resident's needs. Interventions should be related to the risk factors as well as incorporating resident choice to help minimize the risk of a fall .