

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Regency at Whitmore Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272</p> <p>This citation pertains to MI00149592</p> <p>Based on observation, interview and record review, the facility failed to prevent misappropriation for one (Resident #202) of three reviewed for misappropriation, resulting in feelings of loss of independence and potential mistrust.</p> <p>Findings include:</p> <p>Review of the Admission Record revealed Resident #202 (R202) was admitted to the facility on [DATE] with diagnoses that included: fracture of neck, anxiety disorder, mood disorder due to known physiological condition, major depressive disorder, contracture of muscle, and cervical spinal cord injury, contracture of left and right hands. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/24 showed that R202 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition.</p> <p>On 2/10/25 at 3:20PM, R202 was observed in his room, lying on his back in bed and was easily conversant. R202 explained that Activities Aide (AA) G had helped him with an online purchase and was the last known person to have his social security debit card in their possession. R202 was unsure if AA G took the physical card or if he took a photo of the card. R202 reported that the police informed him that AA G was arrested and charged with 2 felonies for the unauthorized use of his debit card. R202 reported that he didn't want AA G to get in trouble but just wanted restitution for the unauthorized purchases. He went on to explain that the police identified AA G as the perpetrator using footage from a local fast food restaurant and AA G drivers license photo. R202 reported feeling additional loss of independence since his debit card is now managed by his brother (for safe keeping). He reported that he liked to order pizza and snacks, which he reported still being able to do, however there are additional steps and a delay involved now.</p> <p>A review of the Facility Reported Incident investigation revealed on 1/7/25 R202's brother identified R202's Social Security Debit card was missing from a manila envelope that it had been stored in (inside of a black CD case on top of his wardrobe). Several staff members were interviewed, many had knowledge of R202 having a debit card but nobody indicated knowledge of it's whereabouts.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The investigation summary indicated R202 had gone out to the hospital on 12/23/24 and returned 1/4/25, on 1/7/25 CNA H was asked to enter R202's room by his brother, it was at that time the card was discovered to be missing. The (name of local) Police Department was notified and a report was filed. A review of the transactions noted purchases for online gaming from 12/23/24 through 1/7/25. Additionally, there were purchases at a local fast-food restaurant. This information was provided to the investigating officer.</p> <p>Further review of the Facility Reported Incident investigation revealed Action Taken: (AA G) was immediately suspended pending full investigation . Conclusion: unable to substantiate allegation, (R202) notes (AA G) placed it back in the envelope and also notes several people knew where his card was kept. Additionally, the charges on the card were for game purchases and (R202) had purchased a new gaming system on 12/11/24.</p> <p>A review of Separation of Employment Form revealed AA Gs last day worked was 1/15/25 with an Effective Date of Separation of 1/17/25 related to misconduct and violation of company policy.</p> <p>A review of the Action Record Work Rules revealed a termination effective date of 1/16/25 for reasons that included violation of code of conduct and mishandling resident funds for personal use.</p> <p>A review of the Case Report (police report) indicated that the police investigation began on 1/7/25, where the officer confirmed the card was not where R202 normally kept it, on 1/12/25 SW I contacted the police department with an update that the debit card company had provided a transaction summary of all fraudulent online transactions that were made after R202 entered the hospital on 12/23/24. SW I presented the transaction summary to R202 who confirmed that none of the transactions on the card made between 12/23/24 and 1/8/25 were his. From the transaction summary it was shown that the online fast-food purchases were made for pick-up at a location in the same town as the facility. On 1/15/25 the police department made contact with Director of Operations for the fast-food restaurant, through their review it was discovered that AA G had made and picked up orders on 3 different occasions 12/22/24, 12/28/24 and 1/4/25. This was supported by video footage. On 1/16/25 AA G was interviewed at his home where he initially denied using R202's card but later confessed and was arrested at that time.</p> <p>In an interview on 2/11/25 at 2:53 PM, Nursing Home Administrator (NHA) reported that SW I notified her of the missing debit card, the police were notified right away and an investigation was started. NHA reported personally conducting the interviews that took place and that through the facilities investigation they were not able to substantiate misappropriation prior to submission of the 5-day report (post investigation report required by state agency). However, it was later discovered through the police investigation that AA G was the perpetrator.</p> <p>Review of the facilities policy titled Abuse Prohibition Policy updated 9/9/2022, documented in part Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property .It is the responsibility of all staff to provide a safe environment for guests/residents .If the accused is an employee of the facility, he/she will be suspended until the investigation has been completed .</p>		