

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 08/28/2025
NAME OF PROVIDER OR SUPPLIER Regency at Whitmore Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 8633 N Main Street 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, interview and record review, the facility failed to thoroughly investigate for two out of two residents (Resident #1, and Resident #3) allegations of abuse. Review of a facility reported incident (FRI) dated 07/07/25 at 5:45pm and reported to the state on 07/07/25 at 6:31 PM. 5 day follow up dated 07/10/25. R2 and CNA L were walking on hall 200 when R2 told R1 oh you look like you need a kiss, bent down and kissed R1 on the lips. R1 responded to R2 by telling R2 he was going to tell on her and called her a bitch. CNA L separated them and took R2 to another area. Social workers met with both residents. R2 did not recall the incident and remained ambulatory throughout the facility.R1 did recall the incident and was educated about the use of profanity and the need to call for staff for assistance.R1 was witnessed by LPN M yelling at R2, Get the fuck away from me. According to R1, R2 allegedly kissed him, and he shouted profane words towards her. LPN M immediately separated the residents. Resident # 2 (R2)Review of the medical record reflected R2 was a female who was admitted to the facility on [DATE]. Diagnoses of Alzheimer's Disease with early onset and Depression.R2 resided in the 100 hall. Per the census R2 was moved out of the dementia until and transferred to the 100 hall to room [ROOM NUMBER]-2 on 07/08/2025.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/26/2025, revealed R2 had a Brief Interview of Mental Status (BIMS) of 5 out of 15 (severe impairment) and is independent with transfers, walking. Resident # 1 (R1)Review of the medical record reflected R1 was admitted to the facility on [DATE]. Diagnoses of, generalized anxiety, major depression, Bi-polar disorder, schizoaffective disorder and dementia.The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/01/2025, revealed R2 had a Brief Interview of Mental Status (BIMS) of 15 out of 15 (cognitively intact) and is dependent on mechanical lift to transfer from surface to surface, wheelchair bound. Resident #3 (R3)Review of the medical record reflected R3 was admitted to the facility on [DATE]. Diagnoses of vascular dementia, adjustment disorder with mixed emotions, cognitive social/emotional deficit and major depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) revealed R3 had a Brief Interview of Mental Status (BIMS) of 14 out of 15 (cognitively intact) and is dependent on mechanical lift to transfer from surface to surface, wheelchair bound.During the onsite investigation another incident occurred in which the facility provided the FRI. Upon review of the FRI on 08/14/2025 at 11:00AM, R2 was walking throughout the facility with a staff person providing intermittent supervision, and R2 told R3 that he looked like he needed a kiss and bent down and kissed him on the lips.During an interview on 08/27/2025 at 9:30 AM, Social Worker (SW) H stated that R2 attended activities, ate her lunch and dinner in the dining room and slept well all night. SW H added that R2 had the same routine now that she had back in the memory care unit. SW H stated that when they moved her off the memory care unit, her care plan was updated and had intermittent one to one supervision at times. SW H stated they were monitoring R2 as a team, SW H did not elaborate on what that m. SW H stated after the incident on 07/07/2025, SW H updated R2's nonpharmacological services, referred her to psychiatric services, medication changes to decrease her libido. After the incident on 08/14/2025, she referred R2 back to psychiatric services, stated she was not sure if there were any medication changes or not. SW H stated she continued having conversations with R2's sister who was her durable power of attorney as they looked for another female facility that was a female only locked unit. SW H stated R2 was supervised throughout the day doing her normal activities. SW H stated they had intermittent one on one more so in the evening hours of 8:00pm to 10:00pm. Writer asked SW H if they had done any root cause analysis regarding R2's inappropriate behaviors towards R1 and R3. SW H stated not really.Record review revealed R2 had started seeing psychiatric services before the first inappropriate sexual behavior had accrued, so referring R2 back to psychiatric services was not a new intervention. R2 was seen by psychiatric services on the following dates, 03/17/2025, 04/03/2025, 04/09/2025, 04/17/2025, 05/15/2025, 05/23/2025, 06/26/2025, 07/09/2025, 08/05/2025 and 08/20/2025. Review of R2's medication administration record (MAR) revealed R2 was never ordered a medication that would decrease her libido and therefore had never taken such medication.During an interview on 08/27/2025 at 10:38 AM, SW H stated they would continue non-pharmacological actions as they are detailed in her care plan. SW H added that the new interventions were for psychiatric services. SW H told writer to talk to LNA A about the one-on-one supervision for R2, as she was unclear.During an interview on 08/27/2025 at 1:55 PM, Director of Nursing (DON) B was asked why R2 was removed off from the memory unit? DON B stated R2</p>		

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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. (continued on next page)		

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[NAME] has HX of making sexual innuendos, sticking her tongue out, showing of fingers, doting behavior and drawing out attention toward particular male peer which was ceased since transition off of memory care unit. HX of peck kissing another male peer, dated 05/15/2025 revealed that all the interventions were dated 05/25/25 and there was no interventions added after 07/07/25 nor the 08/14/25 incidents of R2 kissing R1 and R3.Further review of R2's care plan revealed no other care plan or interventions were in place that addressed R2's inappropriate touching of other residents.During an interview on 08/27/2025 at 9:30 AM, Social Worker (SW) H stated that R2 attended activities, ate her lunch and dinner in the dining room and slept well all night. SW H added that R2 had the same routine now that she had back in the memory care unit. SW H stated that when they moved her off the memory care unit, her care plan was updated and had intermittent one to one supervision at times. 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