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	03/31/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on interview and record review the facility failed to report an allegation of staff to resident abuse to the State Agency for one (Resident #107) of two reviewed. Findings include: Review of the clinical record revealed Resident # 107 (R107) was admitted to the facility on [DATE] with diagnosis that included dementia. Review of the Minimum Data Set (MDS) dated [DATE] reflected R107 scored 9 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status. Nursing progress notes dated 11/18/2024 revealed R107 reported a Certified Nursing Assistant physically and verbally abused him and that the Nursing Home Administrator (NHA) A and Social Worker (SW) L were notified. On 03/27/25 at 12:54 PM during an interview with SW L she reported she was aware of R107's allegation of abuse and stated she interviewed R107 and R107's spouse. R107 was unable to give a physical description but not the name of the alleged perpetrator/employee, R107 had some confusion and was potentially thinking of an incident that occurred somewhere else therefore abuse was not substantiated. When queried why nothing was documented in R107's the clinical record by SW L and if the incident was reported to the State Agency, SW L reported that was the NHA A's decision to make. On 03/27/25 01:10 PM Interview with Registered Nurse/Unit Manager (RN UM) M stated she was aware of allegation of abuse stated NHA A handled the situation and she uncertain of the outcome. On 03/27/25 03:05 PM, during an interview with NHA A was able to recall R107's allegation of abuse made on 11/18/2024. NHA A stated SW L interviewed R107 and R107's spouse and it was abuse was not substantiated therefore it was not reported to the State Agency. NHA A elaborated that the facility self reports to the State Agency frequently, when queried if those self reports all have substantiated abuse, NHA reported no. When asked to clarify if unsubstantiated investigations get reported to the State Agency why would R107's allegation of verbal and physical abuse did not get reported. NHA A offered no explanation. It was queried if the allegation of abuse was substantiated or unsubstantiated would that not be the conclusion of the investigation and submitted to the State agency as part of the 5 day investigation? NHA A offered no response. (continued on next page)

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
	235545	A. Building B. Wing	03/31/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy title Abuse Prohibition Policy dated 12/01/2012 with a revision date of 09/09/22, page 8. section G. Reporting abuse and facility Response to the allegation 2. The Administrator or designee will notify the guest/residents representative. Also, any State or Federal agencies of the allegations per state guidelines (2 hours if abuse allegation or serious injury; all others no later than 24 hours). At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action.

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	03/31/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 27446 Based on observation, interview, and record review the facility failed to ensure comprehensive care plans were developed and implemented to meet the needs for two (Residents 101, and 108) out of 30 residents. Findings included: Resident #101 (R101): Per the facility face sheet R101 had resided at the facility since 4/4/2023. Diagnoses included spinal cord injury, contractures of both hands and fingers, and muscle contractures. Review of a photo dated 12/17/24, of R101's buttocks area reveal moisture associated skin damage (MASD-damage of the skin cause by being constantly moist from things such as urine), and a stage III pressure ulcer (PU) (full thickness tissue loss, fat may be visible). The photo also had an assessment documented which revealed the PU was a stage III (3) in-house acquired PU. The PU was located on R101's right buttocks, and was documented as new on 12/17/2024. In an observation on 3/26/2025 at 3:02 PM, of R101's buttocks wounds it was observed R101 had MASD, and an open approximately 3 centimeter (cm) wound that was located in the same place as the stage 3 wound identified on 12/17/2024. The wound was observed to be a stage III that showed a beefy red bed, and no dressing was noted to be in place. Review of the photos dated 12/17, 12/18/2024, and 1/7/2024 revealed R101 had MASD in each photo, and also at the time of the observation on 3/26/2025. Review of R101's care plan revealed a care plan was in place for R101 being at risk for impaired skin integrity, dated 4/4/2023, and last revised on 6/11/2024. The last intervention revision was on 1/4/2025, and that was to turn and reposition R101 from side to side as tolerated or will allow. In an interview on 3/27/2025 at 2:50 PM, with Licensed Practical Nurse (LPN) K stated R101 did not have a wound, but had MASD. LPN K said R101 did have a wound on his buttocks at one time. LPN K said R101's MASD had not resolved because he refused everything. LPN K said it was hit or miss with R101 because he had refused a low air loss mattress and ROHO (air mattress) mattress, it was hit or miss with turning him, he refused to eat, refused care, refused splints, refused heel boots at times because he is angry with his situation. LPN K did not state any possible staff concerns for the reason R101 had continuous MASD. Furthermore, LPN K was not aware that R101 had an open area to his buttocks as observed on 3/26/2025. No care plan was in place for R101's MASD or stage III PU, and there was no care plan in place that addressed R101's refusals and care needs or reasons for refusals. Resident #108 (R108): (continued on next page)

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	03/31/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility face sheet revealed R108 had resided at the facility since 10/18/2024. During an interview on 3/24/2025 at 11:05 AM, R108 stated she had a PU on her right foot on the ball of her foot. R108 removed her shoe and sock and allowed the wound to be observed. The wound observed to be approximately a 2 x 2 cm scab and was unstagable (U), R108 stated that it was very painful. Resident # 108 also stated that she had another PU on her buttock, but stated she did not know when that one occurred. R108 was in her wheelchair during the interview, and was observed to attend to her own needs at will. R108 stated that she was able to use the bathroom if someone would assist her to the bathroom. Review of a Clinically Unavoidable Pressure Injury-V2 document revealed the facility assessed R108 to have an PU that was a DTI (deep tissue injury-appears as a purple/dark area on the skin that is not open) on her right foot and sacrum (buttocks area). The document revealed the DTI developed on 1/15/2025 and was determined to be unavoidable on 2/6/2025, 22 days later. The document revealed that R108's PU were clinically unavoidable due to malnutrition, Braden score (score that determines the likelihood of skin breakdown), and terminal diagnosis, and revealed R108's Braden score was 11 (high risk), was signed on to Hospice services, and had poor food intake. Further review of the Clinically Unavoidable Pressure Injury-V2 document revealed that the interventions in place were, barrier cream (cream placed on the skin), a pressure reducing mattress on the bed, off-loading bony prominences (not allowing bone areas of the body to rest on the bed mattress), and other positioning devices. However, interventions that were listed on the document but were not checked as interventions in place were, Turn q (every) 1 hour, turn q 2 hours, RD (Registered Dietician) consult, Draw-sheet (used to pull resident up in bed to prevent friction), Trapeze (a bar above the resident's bed so resident can move self around), Pressure Reducing Equipment in Chair, Resident/Guest/Family Education, and would also address R108's clinical reasons for skin breakdown. Review of a Skin & Wound Evaluation V7.0 dated 1/28/2025 revealed R108 was noted to have a pressure ulcer to her sacrum on 1/15/2025. The pressure ulcer was documented to be unstagable, and was acquired at the facility. The evaluation revealed that the wound was 50% filled with granulation tissue (new good tissue that forms on the wound during the healing process), and 50% filled with slough (dead dark tissue). The wound measured 7.2 x 3.3 x 2.9 x 1.2 cm (area, length, width, and depth) with 5.0 am of undermining (area under the edges of the wound that is not attached). The evaluation revealed the PU was deteriorating. Upon review of the photograph of the pressure ulcer to R108's sacrum it was revealed that the wound was a stage IV (4) wound with undermining, red edges, and a visible wound bed at the deepest point. Record review of a Skin & Wound Evaluation V7.0 dated 2/5/2025, revealed R108 had a PU that was documented to be unstageable due to slough and/or eschar (hard, dry, back or brown dead tissue scab like covering) on her sacrum. The evaluation revealed the wound was acquired at the facility. The exact date of the wound was 1/15/2025. The wound measured 8.9 x 3.5 x 3.0 x 1.5 cm with 2.4 cm of undermining. The evaluation also revealed that the wound was 80% filled with granulation, and 20% of the wound was filled with slough. The evaluation revealed that the interventions were incontinence management, moisture control, nutrition supplementation, and repositioning devices. (continued on next page)

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	03/31/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the photograph of R108's wound to her sacrum dated 2/5/2025 revealed a stage IV wound that was not unstagable due to the deepest part of the wound bed was clearly visible and not obscured. The wound bed revealed beefy red exposed muscle, and some slough present. Review of a Skin & Wound Evaluation V7.0 dated 3/26/2025, revealed R108's sacral PU continued to be documented as an unstagable wound. The evaluation did not have any dressing treatment documented. Review of the photograph of R108's sacral wound dated 3/26/2025, revealed a stage IV beefy red wound bed that was visible at the deepest depth, and therefore was stagable. Record review of R108's care plans revealed a care plan was in place that had a Focus of (R108) is at risk for impaired skin integrity related to fragile skin. I (R108) am on Hospice. I frequently refuse to reposition and prefer to lay on my left side, dated 1/31/2025, and last revised on 2/25/2025. The care plan did not have an intervention that addressed R108's refusals to reposition, nor did the care plan have an intervention listed on how to approach or encourage R108 when R108 refused to reposition due to impaired skin integrity. The care plan also did not list an intervention on coordinating care with Hospice regarding R108's increased risk for impaired skin integrity. Review of a care plan dated 1/15/2025 and revised on 3/13/2025, revealed R108 have a Focus area of (R108) has an Actual impairment to skin integrity r/t (related to) 1) unstagable pressure injury to medical sacrum. 2) R (right) plantar (sole of the foot) foot DTI. The Focus also revealed, (R108) frequently refuse to reposition and prefer to lay on my left side. Additionally, the Clinically Unavoidable Pressure Injury-V2 document, as written above, revealed the interventions of off-loading bony prominences, and other positioning devices were in place, however these interventions were not listed as an intervention on R108's care plans. Further review of the care plan revealed that there were no interventions listed on R108's Actual impairment to skin integrity care plan that addressed R108's refusals to reposition and preferences to lay on her left side. There were no interventions to re-approach, attempt to understand R108's comfort levels, pain levels, no interventions to turn or reposition R108, no interventions to offer R108 to get out of bed to chair, no interventions to prop R108 off of bony prominences to relieve pressure areas, and there were no interventions to coordinate with Hospice any needs R108 may have with her pressure ulcers and interventions. In an interview on 3/27/2025 at 3:01 PM LPN K stated that she did not perform a root cause analysis to determine why R101 and R108 had developed PU at the facility. LPN K stated that she talks about the resident's wounds and only verbally discuss resident's wounds in the Quality Assurance Performance Improvement (QAPI) meetings, but stated she had no documentation of that. LPN K stated that no meetings were held with Director of Nursing (DON) B to discuss PU, the root causes, and put a plan into place for further prevention of PU. In a further interview with Registered Nurse (RN) M, who was also a wound care nurse, RN M stated that she was always told that whatever stage a wound was staged at for the very first time was where the wound was to always be stage at up until the wound closed. (continued on next page)

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	03/31/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/31/2025 at 2:06 PM, DON B the UM stated that with the wounds she just assists LPN K and RN M in getting the equipment needed for residents with wounds, such as mattress, cushions, or coordinate with the dietician or therapy. DON B stated that she met weekly with LPN K and RN M to go over the resident's wounds, and that was when she would find out what equipment or coordination they needed from her. DON B stated she had not performed any audits, root cause analysis or put a plan into place to ensure healing of current wounds nor preventions of further wounds.

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	03/31/2025

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 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. 27446 Based on observation, interview, and record review, the facility failed to ensure one out of 30 residents care plan interventions were appropriately revised. Findings Included: Per the facility face sheet Resident 101 (R101) had resided at the facility since 4/4/2023. Diagnoses included contractures of right, left hand, and muscles. Review of a care plan dated 1/20/2025, revealed, I (R101) have contractures to: Bilateral ankles Bilateral wrists/hands, Bilateral elbows. The interventions were, Provide the following assistive devices as tolerated, .Right and Left hand splints, Right and left elbow splints., dated 01/20/2025. On 3/25/2025 at 9:42 AM, R101 was visited but was asleep, however it was observed R101 had severe hand and finger contractions with the right fingers contracted into a z shape, and the left hand was observed to have all fingers contracted into the palm with the wrist severely bent backwards. A wash clothe was observed to be inside of R101's left hand. R101 was observed to be on his back. During an interview on 3/26/2025 at 3:02 PM, R101's hand splints were observed to be lying on the over the bed table. R101 stated the splints did not fit anymore because staff never put them on him. On 3/27/2025 at 10:05 AM, R101 was observed lying in bed asleep with a wash clothe in the left hand, no splints were observed to be in place on R101's hands. The splints were observed to remain in the same place not touched as the day before when observed on 3/26/25 at 3:02 PM. In an interview on 3/27/2025 at 9:52 AM CNA H stated that R101 was offered to wear the splints every two hours, but may refuse to wear them. CNA H stated R101 used to wear the splints, but not anymore. CNA H did not give a reason as to why R101 did not wear the splints anymore. In an interview on 3/27/2025 at 9:33 AM, Licensed Practical Nurse (LPN) I stated that staff offer R101 the splints to be put on, however LPN I did not know how often R101 was offered to have the splints put on. In an interview on 3/27/2025 at 9:04 AM, Certified Occupational Therapy Assistant (COTA) J stated R101 was evaluated on 3/14/2025, and the goals were for resting hand splints on both hands. COTA J stated it was recommended that R101 wear bilateral (both sides) hands/wrist splints on 11/24/2024, and stated R101 should have been wearing them since therapy ordered them on 11/24/2024. COTA J stated she was never made aware R101 ever refused to wear the splints. Record review of a plan of treatment for start of care for therapy dated 3/14/2025, revealed, .it is recommended that the patient (R101) wear a resting hand splint and an elbow extension splint on right hand on right elbow on left hand and on left elbow, for 4 hours on and 4 hours off in order to improve PROM (passive range of motion) for adequate hygiene. (continued on next page)

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	03/31/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R101's care plan revealed no updates or new interventions have been added to R101's care plan since therapy's recommendations on 3/14/2025 for R101 to wear the splints.

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	03/31/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 27446 Based on observation, interview, and record review, the facility failed to prevent and correctly identify pressure ulcers for two out of seven residents (Residents 101, and 108) resulting in misidentifying of pressure ulcers, and worsening of pressure ulcers. Findings Included: Resident #101 (R101): Per the facility face sheet R101 had resided at the facility since 4/4/2023. Diagnoses included spinal cord injury, contractures of both hands and fingers, and muscle contractures. Review of a photo dated 12/17/24, of R101's buttocks area reveal moisture associated skin damage (MASD-damage of the skin caused by being constantly moist from things such as urine), and a stage III pressure ulcer (PU) (full thickness tissue loss, fat may be visible). The photo also had an assessment documented which revealed the PU was a stage III (3) in-house acquired PU. The PU was located on R101's right buttocks and the facility documented it as new on 12/17/2024. The facility also documented that the PU had granulation, per the assessment, in 100% of the wound. There was no granulation observed in the picture of the wound, but rather beefy bloody red tissue. In an observation on 3/26/2025 at 3:02 PM of R101's buttocks wounds, R101 had MASD, and an open approximately 3 centimeter (cm) wound located in the same place as the stage 3 wound identified on 12/17/2024. Observation of the wound revealed it to be stage III with a beefy red bed, and no dressing noted to be in place. Review of the photos dated 12/17, 12/18/2024, and 1/7/2024 revealed R101 had MASD in each photo, and also at the time of the observation on 3/26/2025. No other photos or assessments were found to have been completed, nor in R101's electronic medical record (EMR). Review of R101's skin assessments provided by Administrator A revealed that the only skin assessments R101 had conducted were on 2/2, 2/12, 2/19, 3/5, 3/12, 3/19, and 3/26/2025. The Administrator did not provide any further skin assessments. The facility did not provide any skin assessments showing they completed any for the months of November and December 2024, and January 2025, and the skin assessments provided did not identify or have documented any new wounds. Review of R101's care plan revealed a care plan was in place for R101 being at risk for impaired skin integrity, dated 4/4/2023, and last revised on 6/11/2024. The last intervention revision was on 1/4/2025, and that was to turn and reposition R101 from side to side as tolerated or will allow. No care plan was in place for R101's MASD or stage III PU. (continued on next page)

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	03/31/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 3/27/2025 at 2:50 PM, Licensed Practical Nurse (LPN) K stated R101 did not have a wound, but had MASD. LPN K said R101 did have a wound on his buttocks at one time. LPN K said R101's MASD had not resolved because he refused everything. LPN K said it was hit or miss with R101 because he had refused a low air loss mattress and ROHO (air mattress) mattress, it was hit or miss with turning him, he refused to eat, refused care, refused splints, refused heel boots at times because he is angry with his situation. LPN K did not state any possible staff concerns for the reason R101 had continuous MASD. Furthermore, LPN K was not aware that R101 had an open area to his buttocks as observed on 3/26/2025. Resident #108 (R108): Review of the facility face sheet revealed R108 had resided at the facility since 10/18/2024. During an interview on 3/24/2025 at 11:05 AM, R108 stated she had a PU on her right foot on the ball of her foot. R108 removed her shoe and sock and allowed observation of the wound. The wound observed to be approximately a 2 x 2 cm scab and was unstageable (U). R108 stated that it was very painful. R108 also stated that she had another PU on her buttock, but stated she did not know when that one occurred. R108 was in her wheelchair during the interview and observed to attend to her own needs at will. R108 stated that she was able to use the bathroom if someone would assist her. In an interview and observation on 3/24/2025 at 11:13 AM, R108 had a catheter. R108 stated she stated did not know why she had a catheter, and she wanted it taken out. R108 said she had asked to have it removed but staff did not provide an answer as to when the catheter could come out. R108 stated she used the bathroom before staff placed the catheter and wanted to use the bathroom now to urinate and have bowel movements. R108 stated it was humiliating because she also had to wear what R108 called a diaper. Review of a Physician's order dated 2/3/2025, revealed an order for R108 to have a catheter placed related to an unstageable sacral wound, and end of life care. In another interview on 3/27/2025 at 12:26 AM, R108 stated again that she wanted the catheter out, and again said she asked Hospice about having it removed but received no real answer. Record review of R108's skin assessments that staff provided upon request revealed that the only skin assessments that staff conducted were on 2/5, 2/12, 2/27, 3/6, 3/13, and 3/20/2025, and the skin assessments did not identify or have documented any new wounds. Review of a Clinically Unavoidable Pressure Injury-V2 document revealed the facility assessed R108 to have a PU that was a DTI (deep tissue injury-appears as a purple/dark area on the skin that is not open) on her right foot and sacrum (buttocks area). The document revealed the DTI developed on 1/15/2025 and was determined to be unavoidable on 2/6/2025, 22 days later. The document revealed that R108's PU's were clinically unavoidable due to malnutrition, terminal diagnosis, poor food intake, and revealed R108's Braden score (score that determines the likelihood of skin breakdown) was an 11 (indicating high risk), and that Hospice services were providing cares for R108. (continued on next page)

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	03/31/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Further review of the Clinically Unavoidable Pressure Injury-V2 document revealed that the interventions in place were barrier cream (cream placed on the skin), a pressure-reducing mattress on the bed, off-loading bony prominences (not allowing bone areas of the body to rest on the bed mattress), and other positioning devices. However, interventions that were listed on the document but were not checked as interventions in place were, Turn q (every) 1 hour, turn q 2 hours, RD (Registered Dietician) consult, Draw-sheet (used to pull resident up in bed to prevent friction), Trapeze (a bar above the resident's bed so resident can move self around), Pressure Reducing Equipment in Chair, Resident/Guest/Family Education, and would also address R108's clinical reasons for skin breakdown. Review of a Skin & Wound Evaluation V7.0 dated 1/28/2025 revealed R108 to have a pressure ulcer to her sacrum on 1/15/2025. The document showed the pressure ulcer to be unstageable and acquired at the facility. The evaluation revealed that the wound was 50% filled with granulation tissue (new good tissue that forms on the wound during the healing process), and 50% filled with slough (dead dark tissue). The wound measured 7.2 x 3.3 x 2.9 x 1.2 cm (area, length, width, and depth) with 5.0 am of undermining (an unattached area under the edges of the wound). The evaluation revealed the PU was deteriorating. Upon review of the photograph of the pressure ulcer dated 1/28/2025, to R108's sacrum it was revealed that the wound was a stage IV (4) wound with undermining, red edges, and a visible wound bed at the deepest point. Record review of a Skin & Wound Evaluation V7.0 dated 2/5/2025, revealed R108 had a documented PU to be unstageable due to slough and/or eschar (hard, dry, black or brown dead tissue scab like covering) on her sacrum. The evaluation revealed the wound was a facility acquired. The exact date of the wound was 1/15/2025. The wound measured 8.9 x 3.5 x 3.0 x 1.5 cm with 2.4 cm of undermining. The evaluation also revealed that the wound was 80% filled with granulation, with 20% filled with slough. The evaluation revealed that the interventions were incontinence management, moisture control, nutrition supplementation, and repositioning devices. Review of the photograph of R108's wound to her sacrum dated 2/5/2025 revealed a stage IV wound that was not unstageable due to the deepest part of the wound bed was clearly visible and not obscured. The wound bed revealed beefy red exposed muscle, and some slough present. Review of a Skin & Wound Evaluation V7.0 dated 3/26/2025, revealed staff continued to document R108's sacral PU as an unstageable wound. The evaluation did not have any dressing treatment documented. Review of the photograph of R108's sacral wound dated 3/26/2025, revealed a stage IV beefy red wound bed that was visible at the deepest depth, and therefore was stageable. Record review of R108's care plans revealed a care plan was in place that had a Focus of (R108) is at risk for impaired skin integrity related to fragile skin. I (R108) am on Hospice. I frequently refuse to reposition and prefer to lay on my left side, dated 1/31/2025, and last revised on 2/25/2025. The care plan did not have an intervention that addressed R108's refusals to reposition, nor did the care plan have an intervention listed on how to approach or encourage R108 when R108 refused to reposition due to impaired skin integrity. The care plan also did not list an intervention on coordinating care with Hospice regarding R108's increased risk for impaired skin integrity. (continued on next page)

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	03/31/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a care plan dated 1/15/2025 and revised on 3/13/2025, revealed R108 have a Focus area of (R108) has an Actual impairment to skin integrity r/t (related to) 1) unstageable pressure injury to medical sacrum. 2) R (right) plantar (sole of the foot) foot DTI. The Focus also revealed, (R108) frequently refuse to reposition and prefer to lay on my left side. Further review of the care plan revealed that there were no interventions listed on R108's Actual impairment to skin integrity care plan that addressed R108's refusals to reposition and preferences to lay on her left side. There were no interventions to re-approach, attempt to understand R108's comfort levels, pain levels, no interventions to turn or reposition R108, no interventions to offer R108 to get out of bed to chair, no interventions to prop R108 off of bony prominences to relieve pressure areas, and there were no interventions to coordinate with Hospice any needs R108 may have with her pressure ulcers and interventions. In an observation and interview on 3/27/2025 at 12:26 PM, Licensed Practical Nurse (LPN) K, who was the wound care nurse, performed wound care on R108's sacral wound. The wound was a stage IV PU, with a beefy red wound bed not obscured by any slough/eschar or granulation tissue. Upon asking what stage the PU was, LPN K stated R108's sacral wound was unstageable. LPN K said the PU was unstageable because that was the highest stage the wound was ever staged at, so that was the stage the wound would always be staged as. Per the Resident Assessment Instrument (RAI) manual 3.0 Version 1.1.9.1 dated October 2024, on page M-24, pressure ulcers covered with slough and/or eschar with a wound bed that cannot be visualized, should be coded (or identified) as unstageable because the true anatomic depth of the soft tissue damage cannot be determined. The manual further revealed that when enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, the stage of the can then be determined. In an interview on 3/27/2025 at 3:01 PM, LPN K stated that she did not perform a root cause analysis to determine why R101 and R108 had developed PU's at the facility. LPN K stated that she talks about the resident's wounds and only verbally discusses resident's wounds in the Quality Assurance Performance Improvement (QAPI) meetings, but stated she had no documentation of that. LPN K stated that no meetings occurred with Director of Nursing (DON) B to discuss PU's, the root causes, or to put a plan into place for further prevention of PU's. In a further interview with Registered Nurse (RN) M, who was also a wound care nurse, RN M stated that she learned that whatever stage a wound was staged at for the very first time was where the wound was to always be stage at up until the wound closed. In an interview on 3/31/2025 at 2:06 PM, DON B stated that with the wounds she just assists LPN K and RN M in getting the equipment needed for residents with wounds, such as mattresses, cushions, and to coordinate with the dietician or therapy. DON B stated that she met weekly with LPN K and RN M to go over the resident's wounds, and that was when she would find out what equipment or coordination, they needed from her. DON B stated she had not performed any audits, root cause analysis or put a plan into place to ensure healing of current wounds or prevent the occurrence of further wounds.

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	03/31/2025

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview and record review the facility failed to ensure podiatry care was provided for one (Resident #107) of one reviewed for foot care. Findings include: Review of the clinical record revealed Resident # 107 (R107) was admitted to the facility on [DATE] with diagnosis that included dementia. Review of the Minimum Data Set (MDS) dated [DATE] reflected R107 scored 9 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status. On 03/24/25 at 11:04 AM R107 was observed resting in bed, family member P was at bedside and reported they visited on a daily basis. Family member P reported being frustrated that their multiple requests for podiatry care was ignored. Family member P reported that she had been cutting R107's toe nails and it was very difficult to do as the nails are so thick, family member P stated she was not able to do anything with one of the nails as it was curling under. Family member P stated she had asked nursing staff and Social Work staff and everybody in between for approximately 5 months and R107 had yet to receive any podiatry services. R107 offered to show surveyor, family member P removed R107's sock R107s second toe nail was observed to be curled under R107's toe, the nail was so long it covered the pad of the toe. On 03/27/25 at 12:54 PM during an interview with SW L she reported she was not responsible for arranging ancillary services. When queried if she recalled family member P's request for R107 to receive podiatry care, SW L did not respond to the question. On 03/27/25 at 01:03 PM, during an interview with Medical Records Staff N she reported that Family member P sought her out and requested Podiatry care on behalf of R107 about one month ago Medical Record Staff N stated she would ensure R107 was seen by the podiatrist on their next visit. During an interview with Licensed Practical Nurse / Unit Manager (LPN/UM) K on 03/27/25 01:13 PM, she reported she was not aware that R107 was in need of podiatry care and Family member P had been attempting this. When queried if the Certified Nursing Assistant (CNA) would document the condition of R107's foot/toe nail, LPN/UM K stated CNA's were to document new open areas, reddened areas etc When queried if the nurse doing routine skin assessment would/should be aware and note the condition of the toes and nails. LPN/UM K agreed a nurse should have made a note and inquire about foot care.

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	03/31/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 27446 Based on observation, interview, and record review the facility failed to ensure for one out of two residents (Resident 101) hands splints were placed on, and a positioning wedge was put into place. Findings Included: Per the facility face sheet Resident 101 (R101) had resided at the facility since 4/4/2023. Diagnoses included contractures of right, left hand, and muscles. On 3/25/2025 at 9:42 AM, R101 was visited but was asleep, however it was observed R101 had severe hand and finger contractions with the right fingers contracted into a z shape, and the left hand was observed to have all fingers contracted into the palm with the wrist severely bent backwards. A wash clothe was observed to be inside of R101's left hand. R101 was observed to be on his back. Review of a care plan dated 1/20/2025, revealed, I (R101) have contractures to: Bilateral ankles Bilateral wrists/hands, Bilateral elbows. The interventions were, Provide the following assistive devices as tolerated, .Right and Left hand splints, Right and left elbow splints., dated 01/20/2025. Review of the Certified Nurse Aid (CNA) Kardex (document that lists the resident's care needs that a CNA refers too) revealed, Provide the following assistive devices as tolerated: Right and Left hand splints, Right and left elbow splints During an interview on 3/26/2025 at 3:02 PM, R101 stated that no staff ever turn him, R101 said he was always on his back 24 hours a day. R101 was observed to be on his back during the interview. A wedge (item used to put underneath a person to prop them up to the right or left side), which was observed to be on the bedside table underneath the television (TV), R101 stated was never used on him, but was supposed to be used to reposition him to his side. R101 said he not be able to turn himself and was total dependent on staff to turn him while in bed. R101's hand splints were observed to be lying on the over the bed table. R101 stated the splints did not fit anymore because staff never put them on him. On 3/27/2025 at 10:05 AM, R101 was observed lying in bed asleep with a wash clothe in the left hand, no splints were observed to be in place on R101's hands. The splints were observed to remain in the same place not touched as the day before when observed on 3/26/25 at 3:02 PM. R101 observed on his back with the wedge still sitting on the bedside table under the TV. In an interview on 3/27/2025 at 9:52 AM CNA H stated that R101 was offered to wear the splints every two hours, but may refuse to wear them. CNA H stated R101 used to wear the splints, but not anymore. CNA H did not give a reason as to why R101 did not wear the splints anymore. In an interview on 3/27/2025 at 9:33 AM, Licensed Practical Nurse (LPN) I stated that staff offer R101 the splints to be put on, however LPN I did not know how often R101 was offered to have the splints put on. (continued on next page)

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	03/31/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/27/2025 at 9:04 AM, Certified Occupational Therapy Assistant (COTA) J stated R101 was evaluated on 3/14/2025, and the goals were for resting hand splints on both hands. COTA J stated it was recommended that R101 wear bilateral (both sides) hands/wrist splints on 11/24/2024, and stated R101 should have been wearing them since therapy ordered them on 11/24/2024. COTA J stated she was never made aware R101 ever refused to wear the splints. Record review of a plan of treatment for start of care for therapy dated 3/14/2025, revealed, .it is recommended that the patient (R101) wear a resting hand splint and an elbow extension splint on right hand on right elbow on left hand and on left elbow, for 4 hours on and 4 hours off in order to improve PROM (passive range of motion) for adequate hygiene. Review of R101's care plan revealed no updates or new interventions have been added to R101's care plan since therapy's recommendations on 3/14/2025 for R101 to wear the splints.

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	03/31/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on interview and record review, the facility failed to ensure the attending physician documented in the medical record that identified medication irregularities were reviewed, the action taken, and/or the rationale for no changes to the medications for one (Resident #72) of five reviewed. Findings include: Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected (R72 was admitted for long term care and resided in the facility's secured dementia unit. R72 scored 3 out of 15 on the Brief Interview for Mental Status (BIMS). Review of the Monthly Medication Review (MMR) dated 5/31/2024 reflected R72 Receives Divalproex and has experienced recent mental status changes including agitation/anxiety. Recommendation: Please consider monitoring - serum ammonia concentration in response to documentation of altered mental status. - VPA level. (Valporic acid) Rationale for Recommendation: Valproic acid containing products have a BOXED WARNING which describes the potential for significant adverse effects related to hepatotoxicity, pancreatitis, and a warning for dose related thrombocytopenia. The Pharmacist recommendation 3 signature lines, one for the Pharmacist which was signed electronically and the remaining two was for the provider and one for the Director of Nursing. Both signature lines were left blank. Further review of the clinical record did not reflect that a valporic acid level was not ordered, nor was there documentation to reflect if the provider agreed or disagreed with the Pharmacist recommendation. On at 03/26/25 03:33 PM during an interview with the Director of Nursing (DON) B she reported the pharmacist recommendations were provided electronically, then they were to be printed and placed in a binder for the Physician/Nurse Practitioner to review and respond to and sign, then the form was to be signed off by the DON, then it went to medical records to be scanned into the electronic medical record. DON B stated she needed time to look into the issue. On 03/26/25 04:10 PM DON B reported she was not able to find any documentation from the provider about a lab order for valproic acid, there was not documentation from the provider regarding agreeing or disagreeing with the pharmacist recommendation. DON B further reported she was and unable to locate the providers signed pharmacy recommendation and offered no explanation as to why she had not ensured the physician had addressed the recommendation.

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	03/31/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103 Based on observation, interview, and record review the facility failed to provide for resident's food choices for 2 residents (R117 and R 28) of 14 reviewed. Resident 28 (R28) On 03/24/25 at 4:30 PM R 28 was upright in bed and able to participate in an interview. R28 pointed out that chef salad is on the meal ticket to be served every day and yet I only get it about once a week. Sometimes it's a nice salad and other times it is just plain lettuce. R 28 said the chef salad is enjoyed when served with toppings. R 28 considers it healthy and said the doctor has encouraged R28 to eat healthy. On 03/26/25 at 9:05 AM during observation and interview R 28 said yesterday at lunch they sent barbecue chicken, and it states on my ticket I can't eat Barbecue sauce. It was covered in sauce. When asked about a salad R 28 said I did not get a salad. On 03/26/25 at 1:20 PM during observation and interview the meal tray and meal ticket was reviewed at the serving area (R 28s room) For lunch there was no salad on the tray. On the tray was ham, collard greens, stuffing, and pie in a cup. Review of R 28's meal ticket showed a standing order for Chef salad, and lemonade. She did get a small lemonade with lunch. Among dislikes the ticket listed barbecue sauce. When asked about the last time a chef salad was served R28 said about a week ago. 03/31/25 at 11:26 AM during interview with the Dietary Manager (DM) C explained that sometimes lettuce isn't fresh for serving so it is thrown it out and kitchen staff waits for a new order. Dietary Manager (DM) also said she wants to be sure residents who want Chef Salad are served not just of lettuce but with toppings such as cucumbers and cheese. When asked if she notifies residents when they are out of preferred food and offers a substitute, DM C said she relies on the staff on the unit to monitor that and request or the resident to request. 49272 Resident 117 (R117) Review of the clinical record revealed R117 was admitted into the facility on [DATE] with diagnoses that included: depression, anxiety, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure. According to the Minimum Data Set (MDS) assessment dated [DATE], R117 scored 12/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition). Review of R117's weights revealed a height of 74 inches (6 feet, 2 inches), most recent weight of 105.8 pounds and a Body Mass Index (BMI-a measure of body weight relative to height) of 13.6. According to the Cleveland Clinic website (https://my.clevelandclinic.org) a BMI below 18.5 is considered underweight. (continued on next page)

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	03/31/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/25 at 10:29 AM, R117 was observed sitting up in bed. When asked if he had any concerns he reported the food is always served cold and the facility is always out of everything, specifically grapes and vegetables, anything that is good for me. R117 also reported that he needed to gain weight, it didn't seem like anyone was in charge or overseeing the meal trays, the meal cart sits in the hallway for 25-50 minutes before any starts passing out the trays to residents, the food that is delivered on his tray does not match what is on his ticket. R117 also reported that the always available menu is not available and that he had made approximately 10 attempts but has never had it delivered, and staff tell him that nobody is in the kitchen. On 3/24/25 at 1:20 PM, resident was observed sitting up in bed with lunch tray in front of him. Observation of R117's meal ticket and lunch tray revealed standing orders for side salad with vegetables and ranch, 1/2 cup fresh grapes, soup (with crackers), none of those items were observed to be included on the resident's tray. On 3/27/25 at 1:50 PM, resident was observed sitting up in bed with lunch tray in front of him. Observation of R117's meal ticket and lunch tray revealed standing orders for side salad with vegetables and ranch, 1/2 cup fresh grapes, 6 fluid oz (ounces) of nutritional juice and soup (with crackers), none of those items were observed to be included on the resident's tray. Lunch consisted of a chicken entree, vanilla yogurt, egg roll, mixed rice, and frozen pineapple. R117 reported that the chicken entree had good flavor but was served cold, the eggroll and rice were also cold. Resident tasted the pineapple and reported that it tasted metallic and reported that several other foods he had been served have as well. Pineapple was pale in color. On 3/27/25 at 3:00 PM, during an interview with Dietary Manager (DM) C when asked how the facility ensures the residents choices/preferences are honored, stated they ask the residents their likes/dislikes within the first few days of them admitting to the facility, that information is put into the computer and it prints out on residents meal tickets, when they are on the line the staff read them and prepare the trays using that information. DM C reported that she completes a monthly audit of meal trays/compliance. This audit includes new residents, residents with allergies, plus randomly selected residents. Reviewed R117's lunch tickets from 3/24/25 and 3/27/25 with DM C, including all items that were not sent for the resident. DM C reported that the facility was out of grapes. DM C confirmed that the nutritional juice and salad with vegetable and ranch are always available and since they are list as standing orders they should have been sent to resident. When asked if she knew why so many items had gotten missed on R117's lunch trays, she reported that maybe they were rushing because they were late on lunch. Review of the facilities policy titled Food Preferences updated 1/9/25, documented in part The Nutritional Services department will offer alternate meals for individuals who do not want to eat the primary meal .Food preferences will be identified on tray tickets to ensure residents are provided with appropriate food items.

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	03/31/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observations, interviews, record reviews, and 8 (R18, R27, R28, R30, R50, R75, R97, R117) of 30 sampled residents who consume food, the facility failed to provide palatable food products effecting 119 residents, resulting in the increased likelihood for resident decreased food acceptance and nutritional decline. Findings include: On 03/24/25 at 12:09 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded: Chicken Cordon Blue - 140.5 Garlic Mashed Potatoes - 148.5 Seasoned Broccoli - 161.2 Dinner Roll - Room Temperature Apricot Halves - 44.6* Beverage (2% Milk) - 40.4 (*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. On 03/24/25 at 12:22 P.M., An interview was conducted with Dietary Manager C regarding the resident food tray delivery schedule. Dietary Manager C stated: We serve the Main Dining Room, Unit 300, Unit 200, Unit 400, and then Unit 100. On 03/24/25 at 12:40 P.M., Resident lunch meal food trays (27) were observed leaving the food production kitchen, within an insulated Cambro transport cart. On 03/24/25 at 12:42 P.M., Resident lunch meal food trays (27) were observed arriving to the Memory Care Unit (300 Unit), within an insulated Cambro transport cart. On 03/24/25 at 12:58 P.M., Resident lunch meal food trays (26) were observed leaving the food production kitchen, within an insulated Cambro transport cart. (continued on next page)

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	03/31/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/24/25 at 12:59 P.M., Resident lunch meal food trays (26) were observed arriving to the 200 Unit, within an insulated Cambro transport cart. On 03/24/25 at 01:01 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for R18's lunch meal food tray: Hamburger - 120.1* Garlic Mashed Potatoes - 127.6* Broccoli - 130.7* Ice Water - 40.2 (*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. On 03/24/25 at 01:05 P.M., An interview was conducted with R18 regarding facility food products. R18 stated: The food is not very flavorful. R18 also stated: The meat products are usually tough and very hard to cut. On 03/24/25 at 01:08 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for R27's lunch meal food tray: Chicken Cordon Blue - 126.6* Garlic Mashed Potatoes - 126.6* Broccoli - 129.0* Apple Juice - 53.9* (*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. On 03/24/25 at 01:10 P.M., Resident lunch meal food trays (21) were observed leaving the food production kitchen, within an insulated Cambro transport cart. (continued on next page)

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	03/31/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/24/25 at 01:12 P.M., Resident lunch meal food trays (21) were observed arriving to the 400 Unit, within an insulated Cambro transport cart. On 03/24/25 at 01:15 P.M., An interview was conducted with R75 regarding facility food products. R75 stated: Food is usually cold. R75 also stated: Food is sometimes warm. R75 additionally stated: Food is rarely hot. On 03/24/25 at 01:25 P.M., Resident lunch meal food trays (22) were observed leaving the food production kitchen, within an insulated Cambro transport cart. On 03/24/25 at 01:27 P.M., Resident lunch meal food trays (22) were observed arriving to the 100 Unit, within an insulated Cambro transport cart. On 03/24/25 at 04:43 P.M., An interview was conducted with R50 regarding facility food products. R50 stated: The food sucks. R50 also stated: The food is less than sub-par. On 03/25/25 at 12:29 P.M., Resident lunch meal food trays (27) were observed leaving the food production kitchen, within an insulated Cambro transport cart. On 03/25/25 at 12:31 P.M., Resident lunch meal food trays (27) were observed arriving to the 300 Unit, within an insulated Cambro transport cart. On 03/25/25 at 12:48 P.M., Resident lunch meal food trays (24) were observed leaving the food production kitchen, within an insulated Cambro transport cart. On 03/25/25 at 12:49 P.M., Resident lunch meal food trays (24) were observed arriving to the 200 Unit, within an insulated Cambro transport cart. On 03/25/25 at 12:52 P.M., Certified Nursing Assistant (CNA) G was observed delivering lunch meal food trays without closing the Cambro insulated transport cart doors. On 03/25/25 at 12:54 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Themapen model CR2032 digital thermometer. The following food product temperatures were recorded for R75's lunch meal food tray: Beef Ravioli - 120.1* Italian Style Vegetables - Not provided due to meal card dislikes list. Garlic Bread - 111.8* Vanilla Ice Cream - 9.8 Beverage (Orange Juice) - 49.8* Beverage (2% Milk) - 43.2* Mashed Potatoes - 115.2* (continued on next page)

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	03/31/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. On 03/27/25 at 09:30 A.M., Record review of the Policy/Procedure entitled: Tray Accuracy and Test Trays dated 11-11-2024 revealed under Policy: It is the policy of this facility to set up trays accurately to provide residents with meal trays correctly reflecting Therapeutic Diets, Proper Texture Diets, and Food Preferences listed on the tray ticket. Record review of the Policy/Procedure entitled: Tray Accuracy and Test Trays dated 11-11-2024 further revealed under Procedure: (2) The items on each tray will be checked against the tray ticket to verify accuracy before the tray is loaded on to the delivery cart by the person working the last station on the tray line. (3) All foods will be covered. (4) The Nutrition Professional will complete a Tray Accuracy Checklist at least weekly to monitor tray accuracy. (5) The Nutrition Professional will complete a Test Tray Worksheet to monitor the food temperature as received by the resident at least weekly. Resident 18 (R18) On 03/24/25 at 10:09 AM R18 was upright in bed and able to participate in an interview. R18 talked about the food and dissatisfaction with cold food. R18 also said food is not appetizing many times based on the way it looks. When asked if there had been discussion with dietary about concerns R18 said yes, I've had meetings with the dietician. The concerns were said to have been ongoing. Further review of the EMR revealed a Resident Council Meeting note entered in February of 2025 regarding food concerns which stated, need improvement - still cold. Resident 28 (R28) On 03/24/25 at 10:13 AM R28 was interviewed and said that some meals are good and some not so good. R28 added, Some food doesn't feel like it has been cooked. The only thing hot we get is chicken pot pie and chicken noodle soup. Resident 97 (R 97) On 03/24/25 at 4:30 PM R97 was interviewed. R97 said the food is awful at times and is cold or barely warm. R97 said that the doctor had recommended eating healthy and in response R97 had said to the doctor it can be hard to do when the food is not edible. Resident 27 (R27) On 03/24/25 at 11:10 AM R27 was interviewed. R27 said, the food is horrid and always cold. R27 also said that concern had been raised during meeting with the dietician as well as concern about a lack of condiments. R27 said the dietician said a bag of condiments would be brought to her. R27 said other than that nothing has changed. R27 also said there are times the food is so bad I go to bed hungry. (continued on next page)

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	03/31/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 30 (R 30) On 03/24/25 at 04:12 PM R30 was interviewed. R30 stated, The food is horrible. Cold and horrible. I'm living on snacks. On 3/26/25 at 10:57 AM the surveyor met with the Resident Council. During the meeting the attendees talked about food concerns. When asked about food council, R18 said that has been talked about and there is interest. R18 explained there is currently no food council though it has been discussed, and the dietician has had intentions of starting a food council. R18 explained the dietician has had a few meetings for a special meal like a barbecue. The attendees of the meeting expressed interest in a future food council program. On 3/27/25 at 1:47 PM the Registered Dietician (DR) D and the Dietary Manager (DM) C were interviewed. DM C said, I do a test tray weekly. I go to a random unit and do one on each unit. I put a tray at the end of the cart and once all trays are passed, I test for temperatures When asked about concern sheets the RD D said concern sheets are followed up on. When asked about the last Resident Council meeting concern RD D said, In February we did get the message from resident council about the concerns about cold food. We instituted temperature audits. When asked about appetizing temperatures for food the DR D responded that it is individualized. When asked if audits are done inviting resident comments? DR D responded, No, that's why we're trying to get back to the food committee. We work closely together. I like going into the dining room and getting inputs. [NAME] table to table and visit and ask how they are liking their meals. Review of the Test Tray Audit Worksheet showed entries and among them the following: 2/19/25 Left Kitchen 12:58 PM Arrived unit 12:59 PM Last try served 1:13 PM Entree 117.3 degrees, Starch 109.8, Vegetable 128.6 degrees, Dessert 69.1 degrees, Juice 59.7 3/17/25 Left kitchen 5:30 PM, Arrived 5:33 PM, Last try served 5:47 PM: Entree 115.0 degrees, Starch 112 degrees, Vegetable 105.2 degrees, Soup 117.3 degrees, Dessert 64.4 degrees. 3/24/25 Left Kitchen 7:26 AM, Arrived unit 7:27 AM. Last tray served 7:50 AM: Entree 102 degrees, Starch 114 degrees, Cereal 146.4 degrees. 49103 Resident 117 (R117) On 3/24/25 at 10:29 AM, R117 was observed sitting up in bed. When asked if he had any concerns, he reported the food is always served cold and the facility is always out of everything, specifically grapes and vegetables, anything that is good for me. R117 also reported that he needed to gain weight, it didn't seem like anyone was in charge or overseeing the meal trays, the meal cart sits in the hallway for 25-50 minutes before any starts passing out the trays to residents. On 3/24/25 at 1:20 PM, resident was observed sitting up in bed with lunch tray in front of him. R117 reported the chicken cordon blue and rice on his tray were cold. On 3/27/25 at 1:50 PM, R117 was observed sitting up in bed with lunch tray in front of him. Lunch consisted of a chicken entree, vanilla yogurt, egg roll, mixed rice, and frozen pineapple. R117 reported that the chicken entree had good flavor but was served cold, the eggroll and rice were also cold. Resident tasted the pineapple and reported that it tasted metallic and reported that several other foods he had been served have as well. Pineapple was pale in color. (continued on next page)

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	03/31/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #50 (R50) On 3/24/25 at 11:58 AM, R50 approached this surveyor in the hallway. He was observed using a motorized scooter and was eager to talk. R50 reported feeling comfortable speaking in the hallway. R50 said the food was sub-par. When asked if he could elaborate, he reported that if they receive a sandwich it comes with one piece of meat and no dressing/condiments, and the quality of the meat is very poor. He further stated that the meal tickets are often not right, meals are super cold, there is a lot of repetition, all the food is frozen, the facility will substitute sherbet for fresh fruit. R50 emphasized how poor the quality of the food is stating that the hot dog is the cheapest of quality and everything is breaded. R50 reported that his concerns are well known by facility staff. 49272

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	03/31/2025

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 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. 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 119 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. Findings include: On 03/24/25 at 09:27 A.M., An initial tour of the food service was conducted with Dietary Manager C. The following items were noted: 2 of 2 can opener assemblies and mounting brackets were observed soiled with accumulated and encrusted food residue. Dietary Manager C indicated she would have staff thoroughly clean and sanitize the can opener assemblies and mounting brackets as soon as possible. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The dry food product (Flour and Oatmeal) storage bin clear plastic scoops were observed stored, within the food product storage bins. Dietary Manager C instructed staff to remove and thoroughly clean and sanitize the dry food scoops immediately. The 2022 FDA Model Food Code section 3-304.12 states: During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the food with their handles above the top of the food and the container; (B) In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon; (C) On a clean portion of the food preparation table or cooking equipment only if the in-use utensil and the food-contact surface of the food preparation table or cooking equipment are cleaned and sanitized at a frequency specified under SS 4-602. 11 and 4-702.11; (D) In running water of sufficient velocity to flush particulates to the drain, if used with moist food such as ice cream or mashed potatoes; (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; or (F) In a container of water if the water is maintained at a temperature of at least 57oC (135oF) and the container is cleaned at a frequency specified under Subparagraph 4-602.11(D)(7). Dry Storage Room: The return-air-ventilation grill was observed loose-to-mount. Five of six mounting screws were also observed missing. The loose-to-mount grill assembly measured approximately 12-inches-wide by 36-inches-long. Dietary Manager C indicated she would contact maintenance for necessary repairs as soon as possible. (continued on next page)

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	03/31/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2022 FDA Model Food Code section 6-501.11 states: PHYSICAL FACILITIES shall be maintained in good repair. On 03/27/25 at 08:45 A.M., Record review of the Policy/Procedure entitled: Maintenance and Repairs of Equipment in Nutritional Services Department dated 12-19-2024 revealed under Policy: It is the policy of this facility that all malfunctions and need for repairs are reported to the Maintenance Department and the Administrator in a timely manner. On 03/27/25 at 09:00 A.M., Record review of the Policy/Procedure entitled: Dietary Cleaning and Sanitation dated 11-19-2021 revealed under Policy: It is the policy of this facility to maintain the sanitation of the kitchen through proper cleaning and sanitizing stationary food service equipment and food contact surfaces to minimize the growth of microorganisms that may result in food contamination. Record review of the Policy/Procedure entitled: Dietary Cleaning and Sanitation dated 11-19-2021 further revealed under Procedure: (12) The Dietary Manager or Dietician will inspect the kitchen thoroughly to ensure cleaning schedules are completed as assigned.

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	03/31/2025

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 27446 Based on interview and record review the facility failed to ensure a representative from the Governing Body had contributed to the facility assessment, and failed to ensure the facility assessment was re-assessed based on a change in resident acuity status potentially affecting all 119 residents who resided at the facility. Findings Included: Review of the facility assessment revealed that the last assessment was conducted on 7/16/2023, and was good through 7/15/2024, however the facility within the last 30 days had seven pressure ulcers with treatments, 42 residents who had falls; with two of the residents having a major injury from a fall, and 13 residents with catheters who required catheter care. The facility assessment was not re-assessed in order to determine if the facility was able to meet the care needs of the residents on a daily basis. Furthermore, the assessment was found to have the Administrator listed as the Governing body, and not the owner or CEO, or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility, and that Administrator A was accountable to, and answered to the Governing Body. The governing body was not listed as a participating contributor to the assessment. In an interview on 3/31/2025 a 2:43 PM, Administrator A stated the facility assessment Governing Body policy lists her as the Governing Body. Administrator A stated she was not aware that she answered to the Governing Body, and she was not the Governing Body herself.

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	03/31/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 27446 Based on interview and record review the facility failed to identify via the Quality Assurance Performance Improvement committee (QAPI) the need for an action plan for pressure ulcers. Findings Included: Per the facility policy and procedure titled Quality Assurance Performance Improvement Committee dated 7/1/2010 and last revised on 4/5/2024 revealed, The QAPI Committee meets quarterly or, more often as necessary to: .develop and implement a QAPI plan .,Develop and implement appropriate plans of action to correct quality deficiencies; and .determines what performance data will be monitored and the scheduled frequency for monitoring the data. The policy further revealed that the responsibility of the QAPI committee was to improve the quality of care in the facility by monitoring performance measures, develop and implement appropriate performance improvement plans to correct quality concerns, and evaluate the effectiveness of the performance improvement plans. It was identified during the onsite survey dated 3/31/2025 that two out of six residents reviewed for pressure ulcers (PU) were found to have a facility acquired PU at a stage III (3) or higher. In an interview on 3/27/2025 at 3:01 PM LPN K, who was the wound nurse, stated that she did not perform a root cause analysis to determine why two out of the three (R101 and R108) had developed PU at the facility. LPN K stated that she talks about the resident's wounds and only verbally discusses resident's wounds in the Quality Assurance Performance Improvement (QAPI) meetings, but stated she had no documentation of that. LPN K stated that no meetings were held with Director of Nursing (DON) B to discuss PU, the root causes, nor to put a plan into place for further prevention of PU. In an interview on 3/31/2025 at 2:06 PM, DON B stated that with the wounds she just assists LPN K and RN M, who were the two wound care nurses, in getting the equipment needed for residents with wounds, such as mattress, cushions, or coordinate with the dietician or therapy. DON B stated that she met weekly with LPN K and RN M to go over the resident's wounds, and that was when she would find out what equipment or coordination they needed from her. DON B stated she had not performed any audits, root cause analysis or put a plan into place to ensure healing of current wounds or to prevent the occurrence of further wounds. In an interview on 3/31/2025 at 2:43 PM, Administrator A stated that the current items the QAPI committee was working on for PU was resident Braden scales (scale that identifies risk level of skin breakdown) in order to see what residents required devices for skin breakdown prevention and air mattresses. Administrator A also stated that families, residents, and therapy were educated on PU. Administrator A stated that this started in November of 2024. Administrator A stated identification of residents who currently had PUs, a deficiency with PU, root cause analysis for each resident in the facility who currently had a PU, and a performance improvement plan (PIP) had not been identified nor put into place. Administrator A was not able to provide any audits or assessments of the residents with PUs that were currently in the facility.

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	03/31/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observations, interviews, record reviews, and 1 (R50) of 30 sampled residents, the facility failed to effectively clean and maintain the physical plant effecting 119 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Findings include: On 03/24/25 at 04:13 P.M., An environmental tour of the facility outdoor smoking area was conducted by this surveyor. The following item was noted: The smoking area canopy roof was observed (worn, warped, missing), allowing seasonal weather events (snow, rain, etc.) to enter the open smoking space. The damaged canopy roof surface measured approximately 24-feet-long by 30-feet-wide. On 03/24/25 at 04:43 P.M., An interview was conducted with R50 regarding the condition of the facility smoking area canopy roof. R50 stated: The smoking area has been bad for quite a while. R50 also stated: I have been here for three years, and the roof has been bad the entire time. On 03/25/25 at 08:55 A.M., An environmental tour of the facility Laundry Service was conducted with Environmental Services Supervisor E. The following items were noted: Clean Laundry Room: The folding table perimeter surface was observed (etched, scored, particulate). The wooden particle board perimeter surface was also observed porous, creating a bacterial harborage space. One of two overhead clear protective light lens covers were additionally observed cracked and broken. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Clean Laundry Storage Room: The overhead light assembly was observed non-functional. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. 100 Hall Soiled Utility Room: The waste hopper cold water supply was observed shut off at the valve. The waste hopper hot water supply valve was also observed leaking water upon actuation. The hand sink basin faucet assembly was additionally observed leaking water at each valve (hot and cold) upon actuation. The entrance light switch pole extension was further observed broken and extremely jagged. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. 300 Hall Soiled Utility Room: The counter laminate surface perimeter edge was observed (etched, scored, particulate, missing). The waste hopper (hot and cold) water valves were also observed leaking water upon actuation. The overhead clear protective light lens cover was additionally observed (etched, scored, broken). Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. (continued on next page)

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	03/31/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	400 Hall Soiled Utility Room: One of two overhead light assemblies were observed non-functional. The waste hopper (hot water) supply valve was observed non-functional. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. On 03/25/25 at 10:25 A.M., A common area environmental tour was conducted with Environmental Services Supervisor E. The following items were noted: Occupational Therapy/Physical Therapy: The staff microwave oven interior ceiling was observed (etched, scored, particulate, corroded). Environmental Services Supervisor E indicated she would have maintenance remove and replace the faulty microwave oven as soon as possible. Staff/Visitor Restroom: The hand sink basin perimeter caulking was observed (etched, scored, convoluted, particulate). Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. 100 Hall Nurses Station Restroom: The commode base seat was observed ill-fitting. The commode base was also observed elongated; therefore, a standard sized seat would not properly accommodate the commode base surface. Environmental Services Supervisor E indicated she would contact maintenance to replace the ill-fitting seat as soon as possible. Personal Protective Equipment (PPE) Storage Room: The painted flooring surface was observed separating from the original ceramic tile base surface. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Shower room [ROOM NUMBER]: The shower wand assembly was observed missing an atmospheric vacuum breaker, to prevent potential back-siphonage between the potable (drinking) and non-potable (non-drinking) water supplies. The hand sink faucet assembly was also observed loose-to-mount. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Shower room [ROOM NUMBER]: The shower wand assembly was observed missing an atmospheric vacuum breaker, to prevent potential back-siphonage between the potable (drinking) and non-potable (non-drinking) water supplies. Four 4-inch-wide by 4-inch-long ceramic wall tiles were also observed broken and/or missing. Two ceramic wall/floor coving tiles were additionally observed loose-to-mount. Two ceramic wall/floor coving tiles were observed cracked and broken, directly below the hand sink basin. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. 200 Hall Nursing Station: The countertop perimeter Formica laminate edges were observed (etched, scored, particulate, missing). The damaged laminate Formica edge surface measured approximately 2-inches-wide by 18-feet-long. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. (continued on next page)

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	03/31/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Shower room [ROOM NUMBER]: The commode base was observed loose-to-mount. The commode base could be moved from side to side approximately 2-4-inches. The shower wand assembly was also observed missing an atmospheric vacuum breaker, to prevent potential back-siphonage between the potable (drinking) and non-potable (non-drinking) water supplies. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Shower room [ROOM NUMBER]: The shower wand assembly was observed missing an atmospheric vacuum breaker, to prevent potential back-siphonage between the potable (drinking) and non-potable (non-drinking) water supplies. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Clean Linen Room: 1 of 2 ventilation grill plates were observed missing. The missing grill plate opening measured approximately 12-inches-wide by 24-inches-long. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. On 03/25/25 at 11:47 A.M., An interview was conducted with Environmental Services Supervisor E regarding the facility work order system. Environmental Services Supervisor E stated: We have the TELS system. On 03/25/25 at 02:20 P.M., A common area environmental tour was continued with Environmental Services Supervisor E. The following items were noted: Main Dining Room: 6 of 15 overhead light assemblies were observed non-functional. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Resident Telephone Room: The resident call system was observed non-functional. Environmental Service Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Activity Room: The restroom overhead light assembly was observed mounted with exposed electrical wiring. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Outdoor Smoking Area: The roof canopy was observed (etched, scored, particulate, missing). The damaged canopy roof surface measured approximately 20-feet-wide by 30-feet-long. 300 Unit The 300 Unit hallway corridor was observed extremely malodorous. The malodorous conditions were also observed to be associated with human feces and urine. Staff Restroom: The commode base caulking was observed (etched, scored, particulate, stained). Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. (continued on next page)

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	03/31/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Shower room [ROOM NUMBER]: The hand sink basin was observed loose-to-mount. The hand sink basin mounting bracket was also observed bent, creating a gap between the sink and wall surface. The gap measured approximately 0.25- 0.50 inches-wide. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. 400 Unit Locker Room: The restroom commode base caulking was observed (etched, scored, particulate). Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Maintenance Storage Room: The room was observed in complete disarray. Several cases of Clorox Clean-Up 360 was also observed moist and possibly leaking. Three rolls of carpeting were additionally observed stored in the corner. One shop vac was further observed stored in the center of the room. Clean Utility Room: The hand sink faucet assembly hot water supply was observed non-functional. The base wall/floor vinyl coving strip was also observed loose-to-mount. The damaged wall/floor vinyl coving measured approximately 6-inches-wide by 4-feet-long. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Shower room [ROOM NUMBER]: The shower wand assembly was observed missing an atmospheric vacuum breaker, to prevent potential back-siphonage between the potable (drinking) and non-potable (non-drinking) water supplies. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Shower room [ROOM NUMBER]: The shower wand assembly was observed missing an atmospheric vacuum breaker, to prevent potential back-siphonage between the potable (drinking) and non-potable (non-drinking) water supplies. The commode base caulking was also observed (etched, scored, particulate). Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. Housekeeping Storage Room: 1 of 2 overhead light assemblies were observed non-functional. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. On 03/26/25 at 08:15 A.M., An environmental tour of sampled resident rooms was conducted with Environmental Services Supervisor E. The following items were noted: 202: The Bed 2 oscillating floor fan was observed soiled with accumulated and encrusted dust/dirt deposits. The restroom hand sink basin was also observed loose-to-mount. 211: The Bed 2 and Bed 3 overbed light assembly pull string extensions were observed missing. The restroom overhead light assembly was also observed with two of three 48-inch-long fluorescent light bulbs non-functional. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. (continued on next page)

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	03/31/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	212: The Bed 1 oscillating floor fan was observed soiled with accumulated and encrusted dust/dirt deposits. Environmental Services Supervisor E indicated she would have staff thoroughly clean and sanitize the floor fan as soon as possible. 307: The restroom commode base caulking was observed (etched, scored, particulate). The Bed 2 overbed light assembly pull string extension was also observed missing. 309: The restroom commode base caulking was observed (etched, scored, particulate). The commode support assembly was also observed soiled with accumulated and encrusted dust/dirt/human waste. 311: The restroom commode base caulking was observed (etched, scored, particulate). The Bed 2 drywall surface was also observed with a small hole, adjacent to the headboard. The damaged drywall surface measured approximately 6-inches-wide by 6-inches-long. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. 402: The Bed 2 oscillating floor fan was observed soiled with accumulated and encrusted dust/dirt deposits. Environmental Services Supervisor E indicated she would have staff thoroughly clean and sanitize the floor fan as soon as possible. 406: The Bed 2 oscillating floor fan was observed soiled with accumulated and encrusted dust/dirt deposits. The restroom commode base caulking was also observed (etched, scored, particulate). The restroom ceramic tile was additionally observed cracked/broken, adjacent to the hand soap dispenser. The damaged ceramic tile measured approximately 4-inches-wide by 4-inches-long. The restroom ceiling maintenance access cover was further observed broken and loose-to-mount. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. 407: The restroom commode base caulking was observed (etched, scored, particulate). The Bed 1 oscillating floor fan was also observed soiled with accumulated and encrusted dust/dirt deposits. 412: The restroom commode base caulking was observed (etched, scored, particulate). The restroom ceramic tile was also observed cracked/broken/missing, adjacent to the hand soap dispenser. The damaged ceramic tile measured approximately 4-inches-wide by 4-inches-long. 414: The restroom commode base caulking was observed (etched, scored, particulate). Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. 417: 1 of 2 overhead light assemblies were observed non-functional. Environmental Services Supervisor E indicated she would contact maintenance for necessary repairs as soon as possible. On 03/27/25 at 08:00 A.M., Record review of the Policy/Procedure entitled: Maintenance Department dated 9-19-2024 revealed under Policy: To assure proper maintenance of the physical plant. Record review of the Policy/Procedure entitled: Maintenance Department dated 9-19-2024 further revealed under IV General Facility Maintenance: The department will do on-going monitoring of the facility for areas needing repair and, if needed, will report to the supervisor for approval of the repairs needed. (continued on next page)

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	03/31/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/27/25 at 08:15 A.M., Record review of the Policy/Procedure entitled: Housekeeping Services dated 2-28-2025 revealed under Policy: To promote a sanitary environment. II. Routine Cleaning of Horizontal Surfaces (A) In resident care areas, cleaning of non-carpeted floors and other horizontal surfaces will be done daily and more frequently if spillage or visible soiling occurs. On 03/27/25 at 08:30 A.M., Record review of the Direct Supply TELS Works Orders for the last 85 days revealed no specific entries related to the aforementioned maintenance concerns.