STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235617	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Nursing & Rehabilitation Center	7700 McClellan Utica, MI 48317

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28776 Based on observation, interview, and record review, the facility failed to transport a resident from a doctors appointment in a respectful manner for one sampled resident (R901) of one reviewed for resident rights. Findings include: On 2/12/25 at 9:32 AM, R901 was observed lying in bed. Certified Nursing Assistant (CNA A) reported that R901 went out yesterday for a medical appointment for their feet. On 2/12/25 at 10:54 AM, R901's Interested Party (IP) reported that R901 had a doctor's appointment for R901's foot, the van was an hour and a half late to pick R901 up for the appointment and late for the return to the facility. The IP also explained that when the van arrived at the doctor's office the driver had two children without car seats inside the van, and was observed cursing and hitting the children in the van. The doctor's office manager approached the driver, and she then began to curse at the office manager. After the exchange the office manager called the facility to report the driver and eventually, decided to allow the resident to ride back to the facility, with the children in the van. The IP explained that she followed behind the van and arrived back to the facility around 5:30 PM. The IP reported that R901 reported that they were hit by the children during the ride back to the facility. On 2/12/25 at 11:30 AM, R901 was asked about their ride back to the facility when the children were in the van. The resident was asked if their were kids on the van, and R901 stated, Yes. R901 was asked if anything happened during the ride with the kids, and R901 stated, They hit me. R901 was asked what they hit them with and stated, A book. R901 was asked did anything else happen, and explained that they were cursing. A review of R901's progress notes revealed: 2/11/2025 02:35 PM Resident left the facility for Infectious Disease appointment by wheelchair in company van . Resident is alert and oriented times 3 (alert and oriented to person, place and time) . 2/11/2025 05:18 PM Resident returned from doctor's appointment with sister. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R901's medical record revealed, R901 was admitted to the facility on [DATE], with diagnoses that included osteomyelitis, right ankle and foot Pressure ulcer of right heel, unstageable, Type II diabetes mellitus with foot ulcer. A review of R901's Minimum Data Set (MDS) five-day admission review dated 2/5/2024 noted, R901 with an intact cognition and dependent of staff to complete ADLs (activities of daily living). On 2/12/25 at 3:47 PM, Nursing Home Administrator (NHA) was asked if they were aware of the incident that occurred at the doctor's office. The NHA reported they were called around 6:30 PM regarding the van's driver with the children and how she was behaving. The NHA explained she then called the sister facility's administrator to report the information to them, because that was it was their driver/van. The NHA was asked if they had followed up with the sister or R901 regarding the drive to the facility, after the driver was observed to hit the two children that were in the van. The NHA explained they did not follow up with R901 or the sister. A review of the facility's policy titled, Transportation Policy dated 1/8/2025 noted, Policy: To provide guidelines for the safe and comfortable transportation of residents to medical appointments and other locations. Policy Explanation and Compliance Guidelines: General Guidelines: . 3. Facility vehicles must not be used for personal use 8. Unsafe Conduct is any act which creates the potential for injury or other risk to any passenger, or driver. 9. Abusive Conduct is any disruptive act toward any passenger, or driver a. This includes, but is not limited to, any acts that are generally offensive, invading the private rights of others, or touching another person in a rude, insolent, or angry manner. The driver may request the rider discontinue the behavior. Riders who continue with the behavior may be asked to leave the vehicle . General Safety 2. Ensure resident dignity is preserved .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 This citation pertains to Intake: MI00149826. Based on observation, interview, and record review, the facility failed to ensure a wound vac (a medical device that uses negative pressure for wound healing) was consistanly applied for one sampled resident (R901) of two reviewed for skin management. Findings include: On 2/12/25 at 9:32 AM, R901 was observed lying in bed, their feet were lying flat on the bed, and without a wound vac on their foot. Certified Nursing Assistant (CNA) A was asked to lift the blanket off R901's feet for observation. R901's right foot was observed without a sock or bandage. R901's left foot was observed wrapped with a white bandage, the foot was observed to be leaking with fluids through the bandage and onto the bed. CNA A was asked where R901's wound vac was, CNA A reported, the resident came back from a doctor's appointment without it on. CNA A was observed to go into a bag and pull out the wound vac. The wound vac was observed with dried blood in the darinage tube and a large amount of blood in the reservoir of the wound vac. On 2/12/25 at 10:54 AM, R901's sister confirmed the resident had an (infectious disease) doctor's appointment (on 2/11/25) for they're foot and they (doctor's office staff) removed the wound vac, but were unable to put it back on because the facility did not send the resident's wound vac supplies. They further explained the Director of Nursing (DON) was at the facility when R901 returned from the doctor's appointment and reported she was leaving for the day and that she would put the wound vac on in the morning (2/12/25) about 7:00 am when they returned to the facility. On 2/12/25 at 11:30 AM, R901 was observed lying in bed with the wound vac not on their left foot. A review of R901's Medication Administration Record (MAR) noted, February 2025 Order: Ensure wound vac to left heel is in place and functioning properly, frequency twice a day. The MAR was noted as blank with no documentation between 7:00 PM - 7:00 AM on the 5th and 10th. On Febraury 11th, the documentation noted, Reason: Not Administered: Other Comment: resident does not have a wound vac. Order: Check wound vac suctioning q2h (every 2 hours). Frequency: Every 2 hours. The following days were without documentation of wound vac application (February) 1st, 5th, 6th, 7th, and 11th (2025). A review of the comments for the 11th through the 12th noted, Reason: Not Administered: Other Comment: resident does not have a wound vac. A review of R901's progress notes revealed: 2/11/2025 02:35 PM, Resident left the facility for Infectious Disease appointment by wheelchair in company van. Wound Vac intact. Face sheet and medications sheet sent with resident. Resident is alert and oriented times 3. [They are a] 2 persons assist with ADLs (Activities of Daily Living) . 2/11/2025 05:18 PM, Resident returned from doctor's appointment with sister. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/11/2025 05:45 PM [Recorded as Late Entry on 02/12/2025 01:28 PM] (R901) returned from ID (Infectious Disease) appt via assisted w/c (wheelchair). A&O x3 (the patient being alert and oriented to person, place and time) denies pain . received no notes from ID ofc.(office) dressing Wet dry replaced moderate serous sangernous drainage O (zero) heighten Oder (odor) wound base remain red. wound Practioner notified, wound vac to continue in am (morning). Further review of R901's medical record revealed, R901 was admitted to the facility on [DATE], with diagnoses that included osteomyelitis, right ankle and foot Pressure ulcer of right heel, unstageable, Type II diabetes mellitus with foot ulcer. A review of R901's Minimum Data Set (MDS) dated [DATE] noted, R901 with an intact cognition and dependent of staff to complete activities of daily living. On 2/12/25 at 1:39 PM, a request to speak with the DON was made, Nurse B reported the DONwas not available. Nurse B was asked about R901's wound vac and reported she had recently put it on today because it wasn't on. Nurse B was asked if she was aware of the reason, it wasn't put on when R901 returned from their outside appointment, and reported she was not sure why it wasn't placed on R901's foot. On 2/12/25 at 3:47 PM, Nursing Home Administrator (NHA) was asked if they were aware of the reason R901's wound vac was not put back on at the doctor's office. The NHA explained she was told the facility did not send the needed supplies to the appointment and the DON was to put it on. A review of the facility's policy titled, Wound Treatment Management dated 11/1/22 noted, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake: MI00150065 Based on observation, interview and record review, the facility failed to document showers for two dependent residents (R903 and R904) of four residents reviewed for complete medical records. Findings include: A review of information provided to the State Agency revealed concerns that female residents were not being adequately showered and groomed. On 2/12/25 at 9:41 AM, R904 was observed in bed on their back. Attempts to interview the resident were to no avail as they appeared confused and refused to speak with the surveyor. A review of R904's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Dementia, Schizoaffective Disorder, and Diabetes. Further review revealed that the resident is enrolled onto hospice and required extensive to total dependence for activities of daily living. On 2/12/25 at 9:45 AM, R903 was observed in bed lying on their back, and asked about receiving showers. The resident explained that they thought they received a shower yesterday but was unsure. A review of R903's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included a Traumatic Brain Injury, Dysphagia, and Chronic Kidney Disease. Further review revealed that the resident has limited to extensive assistance for activities of daily living. On 2/12/25 at 11:42 AM, shower/bathing documentation for the last 60 days was requested from the facility for R903 and R904. On 2/12/25 at 12:30 PM, three shower sheets were provided for R904 for 1/29/25, 2/5/25 and 2/8/25, in which two of those dates the resident refused. There was no shower documentation provided for R903. The Nursing Home Administrator at this time acknowledged that the documentation was lacking and should be completed. A review of the facility's Activities of Daily Living (ADLs) policy revealed the following, .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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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. 40384 This citation pertains to Intake MI00150065. Based on observation, interview, and record review, the facility failed to maintain a homelike environment in the resident showers and ensure the ice machine on the first floor was backflow protected. This deficient practice had the potential to affect all 39 residents in the facility. Findings include: On 2/12/25 at 9:50 AM, the ice machine drain line on the first floor was observed to extend down approximately 2 inches into the floor drain which was observed to have a buildup of black mold. Further observations of the sink located inside the room where the ice machine was located, revealed lime build-up around the faucet aerator. On 2/12/25 at 9:55 AM and 12:30 PM, observations of the facility's two shower rooms were observed with black mold, and an unknown brown substance around the perimeter of the shower, in addition to the shower walls. On 2/12/25 at 4:00 PM, findings of the ice machine and showers were brought to the attention of the Nursing Home Administrator (NHA), and she acknowledged she would look into the concerns. According to the Food & Drug Administration (FDA) 2017 Model Food Code, Section 5-402.11 Backflow Prevention, (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. A review of the facility's Safe and Homelike Environment policy revealed the following, .3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .