STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235655	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Westland	2209 North Newburgh Rd Westland, MI 48185

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, interview, and record review, the facility failed to timely implement care plan interventions following falls for one resident (R107) out of three reviewed for plans of care. Findings include:On 1/27/2026 at 6:30 AM, R107 was observed lying in bed with their feet hanging off the side. R107's bed was not observed in a low position, with a blanket and sling pad underneath them. Registered Nurse (RN) H reported R107 had just returned from the hospital following a fall where they hit their head and was on a blood thinner.A review of the medical record revealed R107 was admitted into the facility on 1/13/2026 with the following medical diagnoses, Muscle Wasting and Atrophy. A review of the most recent Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 5/15 indicating an impaired cognition. R107 also required staff assistance with bed mobility and transfers. Further review of Incident and Accidents (IA) reports noted the following: Date:1/24/2026.Nursing Description: Resident observed on [their] right side on the floor in-front of wheelchair before bedtime.Immediate action taken: Description: ROM (Range of Motion) performed without difficulty. No apparent injuries observed. Date: 1/26/2026.Nursing Description: Resident A&O X 1 (Alert and Oriented x 1), observed on the floor with head down. Abrasion observed to right side of face. Residents appear more confused than usual, old bruise to L (left) ring finger, and R (right) thigh. Unable to follow simple directions. Throwing self to the floor, and on the side of the bed several times with difficulty to redirect. Also, on Eliquis (Blood Thinner) Oral Tablet 5 MG twice a day.Immediate action taken: Description: On call provider.made aware. New order received to send resident to ER (Emergency Room) for eval and tmt (treatment) post fall.A review of R107's fall care plan did not reveal any new fall prevention interventions on 1/24/2026 or 1/26/2026 after R107's readmission back into the facility.On 1/29/2026 at 11:45 AM, an interview was conducted with RN K, they reported when a resident falls in the facility, they (facility staff) talk about the fall in their interdisciplinary team (IDT) meeting and decide what should be put in as an intervention. RN K stated the floor nurse is responsible for putting in a timely intervention after a resident fall. On 1/29/2026 at 1:53 PM, an interview was conducted with the Director of Nursing (DON), they confirmed timely interventions should be put in after someone falls. The DON reported the floor nurse does have guidelines they can follow to put in timely interventions until the IDT meeting occurs.A review of a facility policy titled, Fall Management revealed the following, .4. The licensed nurse will complete.Review and/or revise care plan and link to the resident Kardex (resident care guide).

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

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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** This citation pertains to Intake 2638964Based on observation, interview, and record review, the facility failed to follow physician orders for two residents' (R122, R134) out of three reviewed for physician's orders. Findings include:On 1/27/29 a review of the After (hospitalization) Visit Summary (AVS) for R134 revealed; You will need to be seen in the office for suture staple removal in 4 weeks, Vascular Surgeon, October 16, 2025, 2:50 PM. A review of the medical record revealed R134 was admitted to the facility on [DATE] with the following pertinent diagnoses: Osteomyelitis of Ankle and Foot, Below Knee Amputation of Left Foot (LBKA), and Protein Calorie Malnutrition. R134 had a Brief Interview for Mental Status score of 6/15 indicating severe cognitive impairment. Further review of the medical record revealed on 9/29/25 (1 day after admission into the facility) Physiatry Physician Assistant-Certified (PPA) S, entered an order for the staples to be removed from left below knee stump per protocol. On 1/28/26 at 2:10 PM, an interview with Wound Care, Licensed Practical Nurse (LPN) R revealed on 9/29/25 they noted the staples on R134's left below knee amputation had a skin growth over the staples. At that time, they did not know how long the staples had been in. LPN R then contacted PPA S to assess the wound and subsequently removed the staples causing some bleeding where the staples were overgrown. On 1/29/26 at 1:15 PM, in an interview with PPA S they confirmed on 9/29/25 they assessed R134's staples on the LBKA stump and said the staples were overgrown. Both PPA S and LPN R were unsure how long ago the LBKA surgery had been, so the staples were removed (17 days before AVS documented). On 1/29/26 at 1:22 PM, an inquiry was made to PPA S, regarding a review of the AVS recommendations and PPA S did not remember reviewing them. PPA S revealed after the staples were removed, they contacted the Vascular Surgeon to advise the staples had been removed due to skin overgrowth. PPA said the Vascular Surgeon requested to see R134 earlier than the October 16, 2025, appointment to re-evaluate early staple removal. On 1/29/26 at 1:29 PM, Physician F revealed suture/staple removal is generally the domain of the medical team and in general they would like to see sutures/staples first and review the chart, however sutures had already been removed before they could see them. The suture removal protocol was requested on 1/28/26 and was not provided by survey exit. On 1/27/2026 at 12:08 PM, R122 was observed sitting up in their wheelchair. A back brace was observed on the dresser in the room. On 1/27/2026 at 12:09 PM, an interview was conducted with Family Member (FM) T. FM T reported R122 is supposed to have their back brace on whenever they are out of the bed. FM T reported they were unsure why the back brace was not applied and that R122 should have it on. A review of the medical record revealed R122 admitted into the facility with the following medical diagnoses, Unspecified Fracture of T9-T10 Vertebra and Disorders of Muscle. A review of the most (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 0/15 indicating an impaired cognition. R122 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed the following, Start: 1/8/2026.Status: Active.Order: TLSO (Thoracic, Lumber, Spinal, Orthopedic) Brace to be work when out of bed for back. Start: 1/8/2026.Status: Active.Order: Brace should be applied prior to patient being weight bearing. On 1/27/2026 at 12:10 PM, R122 was observed eating in the dining room in their wheelchair. No back brace was applied. On 1/28/2026 at 9:07 AM, R122 was observed sitting in a stationary chair with their breakfast tray in front of them and their head down on their bedside table. No back brace applied. On 1/28/2026 at 10:25 AM, 10:42 AM and 11:17 AM, R122 was observed up in a stationary chair. No back brace was applied. On 1/29/2026 at 9:58 AM and 11:17 AM, R122 was observed in sitting up in their wheelchair. No back brace was applied. A review of the care plan and progress notes did not note any refusals regarding the application for R122's back brace. On 1/29/2026 at 10:45 AM, an interview was conducted with Licensed Practical Nurse (LPN) U. LPN U reported R122 tends to take off their back brace when it is applied. LPN U reported they put the brace on this morning and has not gone back to check and see if they still had it on. LPN U reported that it should be documented if R122 removed the back brace or refused to wear it. A review of a facility policy titled, Physician's Order revealed the following, .It is the responsibility of the licensed nurse to follow physician orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intakes 2719898 and 2724780. Based on interview and record review, the facility failed to ensure consistent monitoring of residents exiting from the facility for two (R17, R82) of two residents reviewed for supervision and leave of absences. Findings include: R82 A review of the facility reported incident revealed R82 had exited the facility to obtain snacks on 1/17/26 at 4:23 PM. A review of the leave of absence sign out book revealed the resident did not sign out or advise staff they were leaving the building. Review of the medical record revealed, R82 was admitted to the facility on [DATE] with the following relevant diagnoses: Alcohol Dependence, Opioid Dependence, and Frequent Falls. On 1/14/26 R82 had an initial Brief Interview for Mental Status (BIMS) of 11/15 indicating moderate cognitive impairment. Review of the admission record revealed an elopement assessment was completed in conjunction with the nursing admission assessment on 1/13/26 with a score of 6 indicating a low risk. On 1/14/26 an order was entered by Physician F as follows: May go on leave of absence with medications with supervision. On 1/28/26 at 3:10 PM, an interview with Registered Nurse (RN) N revealed they had received a phone call on 1/17/26 from Certified Nurse Assistant (CNA) P at approximately 5:30 PM indicating R82 was missing. RN N and began searching the outside area saying, the ground was slippery and it was dark and cold out (17 degrees Fahrenheit). The nurse said as they searched near a local restaurant, an employee of the restaurant came out and notified them there was a person with a walker and a bag inside. RN N identified R82 and returned them to the facility. At 3:20 PM, an interview with CNA P said on 1/17/26 they were notified by a family member that a possible resident was observed off the property, walking with a walker near a local restaurant. CNA P further revealed the family member stated the possible resident had fallen to his knees, resumed standing and continued walking away from the area. On 1/28/26 at 11:30 AM, an interview with Licensed Practical Nurse (LPN) L provided an assessment which noted an abrasion on R82's knee after the outdoor fall. Wound Care Nurse R examined and treated a skin tear (partial flap loss) .55 centimeters (cm) wide x .65 cm deep, below the right anterior knee. At 12:49 PM, R82 was interviewed regarding leaving the facility. R82 revealed they walked out the front door, spoke with someone's family outside, looked around and it did not seem far to where they wanted to go get snacks, so they headed towards the store. R82 revealed they just walked out, no one spoke to them. When asked about signing out, R82 revealed they must have forgotten. On 1/28/26 at 2:58 PM, Restorative Certified Nursing Assistant (RCNA) M revealed they relieve the staff at the front desk and was working the desk on 1/17/26. RCNA confirmed the process regarding resident's going on a leave of absence (LOA) was to ask an approaching resident if they signed out at the nursing station. RCNA M revealed they were not sure the person, later identified as R82, was a family member or resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/26 at 3:00 PM, an interview with the Nursing Home Administrator (NHA) revealed admission assessments are completed by the assigned nurse. The NHA revealed that the process for a Leave of Absence (LOA) was for the resident to sign in and out in the LOA log book. When a resident is given permission to leave with supervision and resident tries to sign out without supervision, he would be asked to sign out Leave of Absence, Against Medical Advice (LOA-AMA) if the resident insisted on leaving. The NHA reported in this instance R82 did not sign out. On 1/29/26 a video of R82's exit on 1/17/26 was reviewed with the NHA. At the time R82 was seen walking through the lobby toward the front door at approximately 4:23 PM wearing a coat, hat, gloves, sweatpants and gym shoes, the resident was not acknowledged by RCNA M. A review of the facility reported incident revealed R82 was returned to the building at 5:14 PM. R17 A review of a facility reported incident revealed R17 had exited the facility for a smoke break on 01/12/26. A review of the leave of absence sign out book revealed R17 had not signed out in the book which indicated R17 had not notified a nursing staff of their departure. On 01/27/2026 at 6:27 AM, it was reported the wing R17 had lived on had 68 residents. Two nurses and three Certified Nurse Assistants (CNAs) were observed to be on this unit. Staff reported they should have three nurses and four certified nursing assistants (CNAs) to provide sufficient care on the midnight shift. At 6:53 AM, CNA J reported three CNAs and two nurses on R17's unit and also reported the other wing only had two CNAs. CNA J further reported it was 50/50 for short staffing related to call offs and CNAs just not scheduled. On 01/28/2026 at 10:44 AM, Receptionist A reported R17's routine was to exit and re-enter the facility multiple times daily and for variable lengths of time from about 5 to 30 minutes. The receptionist reported the exit and re-entry of R17 were to be logged in the LOA sign out book at the nurse station. It was noted R17 was not required to sign out at the reception desk. 01/28/2026 10:49 AM, CNA B reported R17's routine included walking around the facility and since R17 was a smoker, reported R17 would go outside at least once or twice every day. 01/28/2026 10:53 AM, Licensed Practical Nurse (LPN) C, reported R17 was alert times three and basically independent. LPN C reported R17 went out to biweekly appointments. LPN C did not recall if R17 had signed out on 01/12/26, but was aware R17 made multiple entry and exits during the day. LPN C reported R17 was normally out of the facility for 15 to thirty minutes unless on an appointment. On 01/28/2026 at 11:18 AM and 4:02 PM, a review of R17's actions with the Administrator revealed staff were aware of R17's routine to exit and renter the facility. At 4:02 PM the LOA (leave of absence) sign out log for R17 was reviewed and revealed for the year 2025, R17 signed out once in September, two times in October, and once in December. In January 2026 one entry was reported without an actual dated listed. No entry for 01/12/26 was documented. A request for any additional LOA sign-out documentation revealed no additional sign outs for a LOA was completed since the resident's admission on [DATE]. On 01/28/2026 at 2:22 PM, Unit Manager Registered Nurse (RN) I, reported R17 was an independent (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoker and because the facility was non-smoking, R17 would have to go outside and off property to smoke. On 01/28/2026 4:07 PM, Receptionist, E reported they had known R17 since their admission and generally went out at the same time and about the same number of times each day. On 01/29/2026 at 12:08 PM, the Director of Nursing (DON) was aware R17 would go on LOA, and the nurse should be informed of a resident's departure, even when accompanied by a CNA. On 01/29/2026 at 12:48 PM, Social Worker (SW) G was asked about R17 and reported they had known of R17 since their admission and R17 had consistent LOAs due to the resident ear appointments. R17's care conferences and mental status were reviewed, and it was noted that all Minimum Data Set (MDS) assessments since admission had documented R17 as cognitively intact with a 15/15 Brief Interview for Mental Status (BIMS) score. It was confirmed the last care conference had been held on 02/25/25 and a care plan entry for an LOA was not routinely completed unless there had been a problem. A review of the elopement risk documentation indicated R17 was at No risk. 01/29/2026 2:59 PM, Physician F reported 'leave of absence with medications' orders are only given when residents have capacity (deemed competent). A review of the record for R17 they were admitted into the facility on [DATE] and readmitted [DATE], 01/26/25 and 03/19/25. Diagnoses included Nicotine dependence, Alcohol Dependence, Falls, Stroke and Syncope (Fainting). The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition with a 15/15 BIMs score and R17 was independent for all activities of daily living which included walking without an assistive device. A review of the progress notes revealed no indication staff were aware R17 was not signing out or back in following smoke breaks or appointments. A review of the care plan revealed R17 was at risk for falls. It was confirmed by the Administrator on 01/29/26 at 2:25 PM via email that no care plan for the LOA had been completed. A review of the facility policy titled, Care Planning effective 03/03/25 revealed, .The care plan must be specific, resident centered, individualized and unique to each resident . A review of the policy titled Resident Leave of Absence Policy, dated as last approved on 3/7/2023 revealed the following: Specifically, the IDT shall evaluate whether it is clinically appropriate for the Resident to leave and/or discharge from the Facility without supervision, and/or whether there are any other concerns related to such leaves or discharges whether they be supervised or unsupervised. Such concerns may include, but are not limited to, the Resident's possible use and/or possession of drugs or alcohol, and behaviors involving the possible participation in illegal activities. Further review of the facility policy titled, Resident Leave of Absence Policy dated as last approved on 3/7/2023, .IV. LEAVE PROCEDURE: .2.If the Resident has been approved for a Leave of Absence or is Leaving the Facility Against Medical Advice, the Resident and/or Responsible Party shall make an effort to notify the Facility in advance regarding the date, time location and expected length of a planned leave of absence from the Facility. 3. Residents and/or Responsible Parties shall Sign Out before leaving the Facility for a Leave of Absence by indicating the time of the leave, any family or friends accompanying the Resident during the leave, applicable contact information and the proposed location and estimated length for the leave. Residents or Responsible Parties shall also 'Sign In upon returning to the Facility following a Leave of Absence. If the Resident refuses or fails to Sign In or Out relative to a Leave of Absence, Facility staff should document such information, if (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	known, in the medical record.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. This citation pertains to intake 2648023Based on observation, interview, and record review, the facility failed to complete colostomy (an opening on the abdomen connecting the large intestine to the outside of the body) care for one resident (R148) out of two reviewed for colostomy care. Findings include:On 1/28/2026 at 9:21 AM, R148 was observed lying in bed. R148 was noted to have a colostomy located in their left lower abdomen. R148 reported they had a colostomy and sometimes the staff forgets to empty it. R148 reported if they tell staff, then they will empty it or change it. The resident stated one time their colostomy bag was so full, staff had to take two trips to empty it and were surprised their colostomy bag did not burst.A review of the medical record revealed R148 admitted into the facility on 1/24/2026 with the following medical diagnoses, Colostomy Status and Diverticulitis of Large Intestines. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental status score of 11/15 indicating an impaired cognition. R148 also required staff assistance with bed mobility and transfers. A review of the physician's orders did not reveal any orders related to colostomy care. Further review of the Treatment Administration Record (TAR) did not reveal any documentation related to providing colostomy care to R148.On 1/29/2026 at 9:21 AM, an interview was conducted with Unit Manager (UM) V. UM V reported when a new admit comes in, the admitting nurse should put in the orders for things like a colostomy. UM V reported they complete chart audits and will clean up orders or add missing orders. On 1/29/2026 at 1:51 PM, an interview was conducted with the Director of Nursing (DON). The DON stated they were unsure why the colostomy care orders were not entered on admission. The DON reported the unit managers do chart audits and double check the orders after new admissions.A review of a facility policy titled, Colostomy did not address colostomy care.