STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235657	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Canton	45900 Geddes Road Canton, MI 48188

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** Based on interview and record review the facility failed to report an incident of resident elopement for one resident (R401) of three residents reviewed for elopement. This failure resulted in the facility not identifying or responding to a situation in which a resident exited the facility without supervision, posing a potential risk to residents' health and safety. Findings include: On 6/30/25 at 12:50 PM, during an interview, the Director of Nursing (DON) denied any residents had eloped from the facility. The DON said there was a resident that had attempted to elope but did not actually elope. Upon further interview the DON confirmed R401 had exited the building and was found in front of the facility. On 6/30/25 at 1:00 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA said they did not consider the incident with R401 to be an elopement because R401 did not leave the premises. The NHA was unable to present any evidence where R401 was found or how R401 exited the building or how long the resident was outside the facility unsupervised. On 6/30/25 at 1:30 PM certified nurse assistant CNA A was interviewed and confirmed on 6/23/25 after 8PM R401 was observed outside the facility unsupervised in a hospital gown and pushing a wheelchair. CNA A observed R401 outside of the facility while walking to another unit. On 7/1/25 at 9:00 AM, License Practical Nurse (LPN) B was interviewed and said initially they documented in a progress note on 6/23/25 that R401 had attempted to leave the facility. LPN B said she received clarification that R401 was found outside of the facility but did not make an addendum to the original progress note. LPN B said they did inform the Director of Nursing on 6/23/25 that R401 had left the facility and was found outside. On 7/2/25 at 9:28 AM, during a second interview, the DON said there was no investigation into R401's elopement. The DON said she made the decision to put the incident on paper once the surveyor came out to investigate the concern of alleged elopement. The DON was queried about receptionist coverage when the receptionist was on break. The DON said when the receptionist takes a break, they call the unit, and the receptionist desk is left unmanned. On 7/1/25 at 10:30 AM, in a second interview the NHA was queried about security footage. The NHA said the camera system was not functional. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 nursing progress created by the DON on 7/1/25 at 5:59 revealed the family notified of R401 6/23/25 elopement until 7/1/25. Record review noted, R401 was admitted on [DATE]. R401 had pertinent diagnosis of fracture of right femur, history of falls, abnormal posture, alcohol dependence with alcohol induced dementia, osteoporosis, chronic kidney disease stage three, glaucoma, and sarcopenia (muscle loss). According to the Minimum Data Set (MDS) dated [DATE], R401 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out 15. According to the 4/26/22 facility Elopement Policy documented . elopement occurs when a guest/resident who needs supervision leaves a safe area without authorization . Additionally in a section of elopement policy it states, if guest leaves the facility the facility must complete and file an incident report.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that an incident involving a resident elopement was reported, investigated, and documented in accordance with federal regulations. This failure affected one resident (R401) of three residents reviewed for elopement and had the potential to place the resident at risk due to inadequate supervision and failure to follow established protocols for investigating and reporting incidents. Findings include: On 6/30/25 at 12:50 PM, during an interview, the Director of Nursing (DON) denied any residents had eloped from the facility. The DON said there was a resident that had attempted to elope but did not actually elope. Upon further questioning the DON confirmed R401 had exited the building and was found in front of the facility. On 6/30/25 at 1:00 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA said they did not consider the incident with R401 to be an elopement risk because R401 did not leave the premises. The NHA was unable to present any evidence where R401 was found or how R401 exited the building or how long the resident was outside unsupervised. On 6/30/25 at 1:30 PM certified nurse assistant CNA A was interviewed and confirmed on 6/23/25 after 8PM R401 was observed outside the facility unsupervised in a hospital gown and pushing a wheelchair. CNA A observed R401 outside of the facility while walking to another unit. On 7/1/25 at 9:00 AM, License Practical Nurse (LPN) B was interviewed and said initially she documented in a progress note on 6/23/25 that R401 had attempted to leave the facility. LPN B said she received clarification that R401 was found outside of the facility but did not make an addendum to the original progress note. LPN B said they did inform the Director of Nursing on 6/23/25 that R401 had left the facility and was found outside. On 7/2/25 at 9:28 AM, during a second interview, the DON said there was no investigation into R401's elopement. The DON said she made the decision to put the incident on paper once the surveyor came out to investigate an allegation of elopement. The DON was queried about receptionist coverage when the receptionist was on break. The DON said when the receptionist takes a break, they call the unit, and the receptionist desk is left unmanned. On 7/1/25 at 10:30 AM, in a second interview the NHA was queried about security footage. The NHA said the camera system was not functional. Record review noted, R401 was admitted on [DATE]. R401 had pertinent diagnosis of fracture of right femur, history of falls, abnormal posture, alcohol dependence with alcohol induced dementia, osteoporosis, chronic kidney disease stage three, glaucoma, and sarcopenia (muscle loss). According to the Minimum Data Set (MDS) dated [DATE], R401 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out 15. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 4/26/22 facility Elopement Policy documented . elopement occurs when a guest/resident who needs supervision leaves a safe area without authorization . Additionally in a section of elopement policy it states, if guest leaves the facility the facility must complete and file an incident report.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 intake MI00153910. Based on observation, interview and record review, the facility failed to assess a cognitively impaired resident (R401) after expressing desire to leave the facility and an attempt to exit a back door of the facility on 6/19/25. On 6/23/25 at approximately 8:30 PM, R401 was found after exiting the facility unbeknownst to staff. R401 was located outside the facility in a hospital gown pushing their wheelchair. This resulted in an Immediate Jeopardy due to the facility's failure to identify, assess, and implement interventions to provide resident safety and prevent elopement for residents at risk. The Immediate Jeopardy (IJ) began on 6/19/25. The facility was notified of the IJ on 7/1/25 at 2:30 PM and a removal plan was requested. Findings include: Review of an intake revealed on 6/26/25 an anonymous complainant reported on the evening of 6/23/25 at around 8:30pm, R401 walked out of the front door of the facility, The resident walked out of the facility and continued walking up [NAME] Rd which is the main road. The resident was outside, maybe 10-15 minutes, wearing a hospital gown that opens in the back, pushing her wheelchair. The resident got all the way around to the end of the building. On 6/30/25 at 11:35 AM, the Surveyor observed R401 sitting at the nursing station. R401 was interviewed and said she remembered going outside but did not recall anything else about the incident. Review of nurse progress notes dated 6/19/25 at 6:59 PM, Licensed Practical Nurse (LPN) E documented R401, stated she wanted to go home, I informed (sic) that she is a resident of (Name of Facility). I showed her her room she asked to go back to the nurses station where she was sitting. (R401) She was sitting for 15 minutes and then tried to leave out the back door. Record review noted, R401 was admitted on [DATE] with diagnoses that included fracture of right femur, history of falls, abnormal posture, alcohol dependence with alcohol induced dementia, osteoporosis, chronic kidney disease stage three, glaucoma, and sarcopenia (muscle loss). According to the Minimum Data Set (MDS) dated [DATE], R401 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out 15. A review of R401's care plans revealed no documented evidence of an elopement care plan in place on 6/19/25 when LPN E noted R401 attempted to leave the building. R401's Elopement care plan was initiated on 6/24/25, five days after R401's attempt to exit the building. The Elopement care plan was reviewed and revealed the following: (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- A revision date of 7/2/25, which documented (R401) is at risk for elopement and/or wandering R/T (related to): decrease in cognition, history of attempts to leave facility unattended, impaired safety awareness. The Elopement was created on 6/24/25. - An intervention for 1:1 supervision on afternoon shift was created on 7/1/25. -An intervention for 30-minute visual checks were created on 7/1/25. -The intervention for wander guard to right ankle was created on 6/24/25. -The intervention for distract resident when wandering into inappropriate areas by offering pleasant diversions, structured activities, food conversation was created on 6/24/25. -The intervention to observe wandering behavior and attempt diversional interventional when wandering into inappropriate locations was created on 6/24/24. Review of R401 elopement assessment, dated 4/19/25, revealed R401 was evaluated as a 0 for elopement risk. Review of R401 elopement assessment dated [DATE], R401 was evaluated as a 7. Seven equates to no elopement risk. R401 was reevaluated on 5/19/25. The results were a 7 no risk. R401 was not evelauted for elopment risk after R401 attempted to exit the facility two times on 6/19/25. Further review of progress notes dated 6/23/25 at 8:28 PM, LPN B documented (R401) Resident attempted to leave. Resident redirected to unit. One on one put in place for resident safety. There was no documentation that R401 had actually left the facility. On 6/30/25 at 12:50 PM, during an interview, the Director of Nursing (DON) denied any residents had eloped from the facility. The DON said there was a resident that had attempted to elope but did not actually elope. Upon further interview the DON confirmed R401 had exited the building and was found in front of the facility. On 6/30/25 at 1:00 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA said they did not consider the incident with R401 to be an elopement because R401 did not leave the premises. The NHA was unable to present any evidence where R401 was found or how R401 exited the building and how long the resident was outside unsupervised. On 6/30/25 at 1:30 PM, certified nurse assistant CNA A was interviewed and confirmed on 6/23/25 after 8PM R401 was observed outside the facility unsupervised in a hospital gown and pushing a wheelchair. CNA A observed R401 outside of the facility while walking to another unit. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/1/25 at 9:00 AM, License Practical Nurse (LPN) B was interviewed and said she initially documented in a progress note on 6/23/25 that R401 had attempted to leave the facility. LPN B said she received clarification that R401 was found outside of the facility but did not make an addendum to the original progress note. LPN B said they did inform the Director of Nursing on 6/23/25 that R401 had left the facility and was found outside. On 7/1/25 at 10:05 AM, the Surveyor observed there was no receptionist at the front desk for 15 minutes with multiple visitors entering and exiting the building. This indicated residents could exit the facility unbeknownst to staff On 7/2/25 at 9:28 AM, during a second interview, the DON said there was no investigation into R401's elopement. The DON was queried about staff coverage when the receptionist was on break. The DON said when the receptionist takes a break, they call the unit, and the receptionist desk is left unmanned. On 7/1/25 at 10:30 AM, in a second interview, the NHA was queried about security footage. The NHA said the camera recording system was not functional and was unable to provide evidence of where R401 was located outside of the facility. On 7/2/25 at 11:28 AM, LPN E was interviewed regarding documentation of a nurse's note dated 6/19/25. The nurse's note revealed R401attempted to elope. LPN E explained during the interview that R401 attempted to elope twice on 6/19/25, the first time R401 reached the back door, and the second time approximately 15 minutes later R401 was stopped before reaching the back door. On 7/2/25 at approximately 2:00 pm, the DON and the NHA were informed that R401 had made verbalized leaving the facility with two physical attempts to exit the facility on 6/19/25 without interventions being but in to place. Subsequently, R401 exited the building on 6/23/25 unbeknowst to staff. The DON and the NHA did not provide a response. According to the facility Elopement Policy dated 4/26/22, Elopement occurs when a guest/resident who needs supervision leaves a safe area without authorization .the facility will evaluate guest/resident's risk for elopement upon admission, weekly x 4, quarterly, and with a significant change. Periodic reviews will be completed as deemed necessary by the interdisciplinary team. Upon exiting the facility on 7/2/25 at approximately 3:00 PM no additional information was provided regarding R401's elopement from the facility. Removal Plan. Resident identified to be affected by the alleged deficient practice Resident #R401 was assisted back into the facility on 6/23/25, placed on 1:1 supervision and Q30 minute visual checks Resident #R401 was assessed for Elopement Risk on 6/24/25 Residents with the potential to be affected by the alleged deficient practice. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/1/25 the Administrative Nurses reviewed the residents' most recent elopement evaluation to identify the residents who are at risk for elopement o On 7/1/25 the Administrative Nurses reviewed the residents identified at risk for elopement to ensure care planned interventions are in place to prevent elopement Systemic Measures to Prevent Reoccurrence o On 7/1/25 A QAPI Meeting was held to review the root cause of the elopement, with the NHA, the DON, the Medical Director (by phone), the Social Worker the Social Worker, and Unit Managers. o On 7/1/25 The Elopement policy was reviewed and deemed appropriate. Re-education of the staff on the elopement policy began on 7/1/25, staff must be re-educated before they return to work for their scheduled shift. The facility asserts the immediacy was removed on 7/1/25. The Immediate Jeopardy was removed on 7/2/25, based on the facility's implementation of the removal plan as verified onsite on 7/2/25.