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	06/25/2026

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 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 3027558.Based on observation, interview, and record review the facility failed to provide adequate supervision and follow elopement protocol resulting in R101 leaving the facility unknown to staff and sustaining a fall out of a wheelchair resulting in a facial hematoma, an abrasion to the left hand and right toes for one resident (R101) at risk for immediate jeopardy out of six residents reviewed for supervision.Further investigation of the incident revealed facility staff failed to supervise a severely cognitively impaired resident (R101) with a high elopement risk and respond appropriately to a door alarm (Emergency Door) on the Ridge Unit. R101 was determined to have exited emergency door number 10 at approximately 3:01 PM on 5/20/2026 after setting off the emergency exit door alarm at approximately 3:00 PM. Emergency door number 10 was located on the northwest corner of the building not near a regularly used entrance or parking lot or frequently used driveway. Housekeeper F was observed in security footage turning off the emergency door number 10 alarm at approximately 3:02 PM without checking the area for residents. The facility failed to activate procedures to search for a missing resident. The facility was made aware R101 was outside the facility lying on the ground next to a wheelchair in a driveway approximately 25 yards from emergency exit number 10 by R102 at 3:22 PM. Staff responded to R101 at approximately 3:30 PM. The Immediate Jeopardy (IJ) began on 5/20/2026 when facility staff failed to supervise R101 and initiate a missing person protocol which resulted in R101 exiting the building without staff knowledge. The Nursing Home Administrator (NHA) was notified of the IJ on 6/24/2026 at 1:58 PM. The surveyor confirmed by interview and record review that the IJ was removed on 5/22/2026 but noncompliance remains at a potential for harm due to sustained compliance that has not been verified by the State Agency.Findings include: On 5/21/2026 the State Agency received a Facility Reported Incident.On 6/24/2026 at 9:40 AM, Receptionist B was interviewed and said that on 5/20/2026 at approximately 3:00 PM, she received a phone call from R102 regarding finding R101 outside of the building lying on the ground and appeared injured. Receptionist B said she initiated a missing resident alert. Receptionist B further said that earlier in the day R101 wheeled herself up to the reception area several times and that she notified License Practical Nurse (LPN) C that she was unable to watch R101.On 6/24/2026 at 9:50 AM, R101 was observed in bed. When R101 was asked about the incident that occurred on 5/20/2026 she was unable to recall the event and/or answer questions.On 6/24/2025 at 9:45 AM, R102 was interviewed about the elopement incident that occurred on 5/20/2026. R102 said she was in her room when she heard a door alarm go off around 3:00 PM. R102 said she signed out of the building around 3:15 PM, to cruise around the outside of the facility with her friend. When she approached the back corner of the building (near exit 10) she saw R101 lying on the ground near a wheelchair. R102 said she called the facility to report the incident at 3:22 PM and stayed with R101 until staff responded around 3:30 PM.On 6/24/2025 at 10:00 AM, LPN C was interviewed and said she was assigned to R101 on 5/20/2026. When LPN C was asked if she heard a door alarm, she said she could not recall. When asked if anyone notified her if R101 was agitated or wandering on 5/20/2026 LPN C said she did not remember. LPN further said that she was working on (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the [NAME] unit when R101 eloped on the Ridge unit.On 6/24/2026 at 10:55 AM, the Nursing Home Administrator (NHA) was interviewed regarding the elopement incident which occurred on 5/20/2026. The NHA provided video footage of the incident and identified R101 pushing on exit number 10 emergency door on 5/20/2026 at approximately 3:00 PM which set off the door alarm. Video reviewed with the NHA revealed R101 exiting emergency exit number 10 at approximately 3:01 PM. The NHA identified Housekeeper F turning off the emergency door number 10 alarm at approximately 3:02 PM without checking the area for residents. The NHA said the procedure was for the employee to look for any residents outside the door and then call a missing resident alert. The NHA said Housekeeper F did not follow the elopement procedure. The NHA said Housekeeper F was trained on the elopement procedure on 7/1/2025. The NHA further said Housekeeper F was terminated due to not following the elopement procedure and placing R101 at risk for injury.On 6/24/2026 at 11:15 AM, Scheduler D was interviewed and identified LPN C and Certified Nursing Assistant (CNA) E as assigned to work with R101 on 5/20/2026 during the elopement incident. On 6/24/2026 at 12:30 PM, CNA E was interviewed and said she was assigned to work with R101 on 5/20/2026 but was on break at 3:00 PM when the incident occurred and did not hear the door alarm.On 6/25/2026 at 10:15 AM, Unit Manager/LPN H was interviewed and said she was in her office at the time the alarm went off on 5/20/2026 and did not hear the alarm. LPN H said that LPN I was assigned to work the unit on 5/20/2026 where the elopement occurred but was on break. Unit Manager H said LPN J was expected to cover the ridge unit during LPN I's break.On 6/25/2026 at 10:25 AM, CNA K was interviewed and said she worked on the Ridge Unit on 5/20/2026 at 3:00 PM but did not hear the door alarm because she was working with another resident in the resident's room. On 6/25/2026 at 10:31 AM, LPN I was interviewed and said he was on break at 3:00 PM on 5/20/2026 and did not hear or respond to the door alarm on the ridge unit. LPN I said he told Unit Manager H he was going on break and that he expected Unit Manager H to cover the unit for him.On 6/25/2026 at 11:00 AM, CNA L was interviewed and said she started work at 3:00 PM on 5/20/2026 and did not hear the door alarm.On 6/25/2026 at 11:05 AM, LPN J was interviewed and said she was on lunch break at 3:00 PM on 5/20/2026 and did not hear the alarm sound. LPN J said she notified LPN C and LPN M she was going on lunch break to ensure coverage.On 6/25/2026 at 11:25 AM, LPN J was contacted via phone to attempt an interview with no return call.Record review of R101's Electronic Medical Record (EMR) revealed R101 was admitted to the facility on [DATE] with the most recent readmission on [DATE]. R101 had the following medical diagnoses: Wandering in diseases classified elsewhere, History of falling, Unspecified Dementia and Generalized Anxiety disorder.Review of R101's Minimum Data Set (MDS) dated [DATE] revealed R101 had a Brief Interview of Mental Status (BIMS) score of 3/15 (severe cognitive impairment) and required supervision for wheelchair mobility.Review of the elopement risk assessment dated [DATE], revealed R101 was considered high risk for elopement.Review of R101's care plan revealed, Focus (R101) is at risk for elopement and/or wandering r/t (related to) diagnosis of dementia, history of attempts to leave the facility unattended, impaired safety awareness states I want to go home frequently, requires redirection at time. Increase in confusion and aggression after 3 PM r/t wanting to go home, wander guard left ankle date initiated 7/1/2025, revision on 6/12/2026. Goal Will not leave facility unattended through the review date. Date initiated 7/1/2025 Target Date 9/30/2026. Interventions Observe wandering behavior and attempted diversional interventions when wandering into inappropriate locations such as other residents' rooms when not invited, behind nurses' stations, shower rooms, attempts at exiting facility etc. date initiated 7/2/2025, revised on 6/8/2026.On 6/25/2026 at 11:45 AM, the Director of Nursing (DON) was interviewed and said the expectation is for the nurses on [NAME] Unit to cover for Ridge Unit when the assigned nurse is on break. On 6/25/2026 at 11:55 AM, the NHA was interviewed and said staff did not respond to the emergency exit door alarm per the facilities elopement policy and procedure. The NHA further said the expectation was for residents with a high risk for elopement to be properly supervised. Review of the facility policy titled Elopement Policy last revised 4/26/2022 revealed in part, rounds of all (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	guests/residents are made at the beginning of the shift, at mealtimes and at the end of the shift at a minimum by direct care staff and licensed nurses. Alarm Activation. If an employee hears a door alarm, he or she should: immediately go to the site of the alarm, if no guest/residents found to be exiting the facility, the employee should walk outside, conduct a visual observation of the immediate area to ensure that a guest/resident. In situations where the alarm sounds and a guest/resident is not found to have exited: Notify the licensed nurse immediately and ensure that a head count is completed to ensure that all guests/residents are accounted for.Review of the facility policy titled Nursing Staffing last revised 9/14/2023 revealed in part, the nursing services department provides 24-hour nursing services. The facility ensures sufficient nursing staff. Nursing service is provided by number and type of personnel to ensure that each resident is protected from accidents and injury.The Immediate Jeopardy that began on 5/20/2026 and removed on 5/22/2026 when the facility took the following actions to remove the immediacy:1) On 5/20/2026 the policy on elopement was reviewed by the Administrator and Director of Nursing and deemed appropriate.2) Beginning 5/20/2026, all facility staff education was initiated and is ongoing regarding the elopement policy and procedure.3) On 5/20/2026 All exit doors in the facility were tested to validate alarms were functioning.4) On 5/21/2026 staff identified residents at risk for elopement, care plan updated, wander guard orders were reviewed for placement and function.