STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235710	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Shelby Township	7401 22 Mile Road Shelby Township, 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 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** Based on observation, interview and record review, the facility failed to follow physician orders for three residents (R56, R119 and R117) out of three reviewed for quality of care. Findings include:R56 On 9/22/2025 at 1:15 PM, R56 was observed sitting up in a wheelchair. A gauze wrap and bandage were observed on their right lower extremity (RLE). The bandage was noted to be dated 9/18/2025. A review of the medical record revealed that R56 was admitted into the facility on 5/24/2025 with the following medical diagnoses, Moderate Protein-Calorie Malnutrition and Peripheral Vascular Disease. A review of the most recent Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated an impaired cognition. R56 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed an active wound care order for the right lateral lower leg that was to be changed every Tuesday, Thursday, and Saturday and as needed if missing or soiled for a venous ulcer. A review of the Electronic Medical Record (EMAR) Medication Administration Note noted the following, 9/20/2025 at 14:55 (2:55PM) .Note Text: Unable to complete. Patient was with [their] family celebrating [their] birthday. On 9/23/2025 at 9:33 AM and 12:39 PM, R56 was observed with the same gauze wrap and bandage dated 9/18/2025 on the RLE. The gauze was noted to be soiled. On 9/23/2025 at 2:13 PM, Licensed Practical Nurse (LPN) C was observed changing the dressing. LPN C confirmed that the bandage was dated 9/18/2025 and they were unsure why it was not changed on 9/20/2025 as ordered. On 9/24/2025 at 10:30 AM, an interview was conducted with wound care nurse (WCN) A. WCN A reported they expect for an order to be completed when scheduled. WCN A reported if R56 was busy at the time, the nurse should have come back and tried again or passed it on in report so the as needed portion of the order could be completed on the next shift. R119 On 9/23/2025 at 9:26 AM, R119 was observed laying in bed. R119 was complaining of pain in their legs. R119 was observed to have bilateral above the knee (AKA) amputations and their stumps were laying on the mattress. (continued on next page)

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	A review of the medical record revealed that R119 was admitted into the facility on 9/16/2025 with the following medical diagnoses, Infection of Amputation stump, Right Lower Extremity and Moderate Protein-Calorie Malnutrition. R119 also required staff assistance with bed mobility and transfers. Further review of the physician orders revealed the following, Ordered: 9/16/2025.Offload bilateral AKA stumps with pillows at all times while in bed.Active. On 9/23/2025 at 10:09 AM and 11:48 AM, R119 was observed laying in bed with their stumps lying on the mattress. On 9/24/2025 at 8:54 AM, R119 was observed laying in bed. They indicated they were just given something for pain, and they wanted to be repositioned. R119 stated sometimes they put their stumps on pillows and sometimes they do not. R119 was then repositioned by staff with a pillow placed under their right hip, but their stumps were still lying on the mattress. On 9/24/2025 at 10:07 AM, WCN A observed R119's stumps resting on mattress and placed a pillow under them to float them. WCN A indicated physician orders should be followed as written. On 09/24/2025 at 1:22 PM, a Quality Assurance and Improvement Program (QAPI) meeting was conducted with the Nursing Home Administrator (NHA). The NHA indicated that physician orders and interventions should be followed. On 9/22/25 at 1:25 PM, R117 was observed in their room sitting up in the wheelchair with a cup of water by the bedside. R117 stated that they recently had their tracheostomy removed. On 9/23/25 at 10:05 AM and 2:25 PM, R117 was observed in their room sitting up in a wheelchair and a cup of ice was observed by bedside. On 9/24/25 at 10:15 AM, R117 was observed lying in bed watching television with a cup of ice sitting on the bedside table. A record review of R117's medical record revealed, R117 was admitted on [DATE] with diagnoses of Acute Respiratory Failure with Hypoxia, and Peripheral Vascular disease. R117 was cognitively intact. Further review of the medical record revealed a physician order dated 9/19/25 which stated that R117,may have 1-2 ice chips as needed to moisten oral cavity every 30 minutes to 1 hour as requested.DO NOT LEAVE A CUP OF ICE AT BEDSIDE. On 9/24/25 at 10:20 AM, Registered Nurse (RN) F was unable to explain why an order was written regarding leaving a cup of ice at the bedside. On 9/24/25 at 12:33 PM, an interview occurred with the Director of Nursing (DON) asking about their expectations about the ice chips being left at bedside and not following physician orders. The DON indicated their expectation is that the physician orders are to be followed. On 9/24/25 at 2:06 PM, an interview occurred with the Speech Therapist (ST) G and they were asked about the physician's order. ST G stated there is a risk of aspiration (choking) if R117 has too many ice chips or liquids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Physician's Orders revealed the following: Treatment rendered to a resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to implement interventions for pressure ulcer healing for one resident (R89) out of three reviewed for pressure ulcers. Findings include:On 9/22/2025 at 10:16 AM, R89 was observed lying in bed. Their feet were hanging off the bed, with the head of bed (HOB) flat and they were laying on their back with no positioning devices in place. A green positioning wedge was observed in the chair next to the bed.A review of the medical record revealed that R89 was admitted into the facility on 9/11/2025 with the following medical diagnoses, Pressure Ulcer of Sacral Region, Stage 4 (Full-thickness skin and tissue loss with exposed muscle or bone in the ulcer) and Moderate Protein-Calorie Malnutrition. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R89 also required staff assistance with bed mobility and transfers.Further review of the physician orders revealed the following, Ordered: 9/11/2025.Order: Verify wedge pillow is in use and reposition Q2 (every 2) hours as tolerated. Notify MD/WC (Medical Doctor/Wound Care) of any changes.On 9/22/2025 at 1:13 and 2:00 PM, R89 was observed to be eating lunch with the HOB elevated. Their positioning wedge was observed to be in the chair.On 9/23/2025 at 9:57 AM, R89 was observed laying on their back with the HOB flat. No positioning wedge was observed to be in place.On 9/24/2025 at 9:00 AM, R89 was observed to be up in their chair. The positioning wedge was noted to be in the closet. R89 stated they have not had the wedge used in a while and that they did use it for a little while last night because they were complaining of pain in their left shoulder. R89 stated the wedge helped keep the pressure off and helped with the pain.On 9/24/2025 at 10:20 AM, an interview was conducted with Wound Care Nurse (WCN) A. WCN A reported R89 should be repositioned every 1-3 hours as tolerated and that there is an order to verify that the wedge is in place. WCN A reported that R89 can turn a little but does better with assistance which is why they put the wedge in place.On 09/24/2025 at 1:22 PM, a Quality Assurance and Improvement Program (QAPI) meeting was conducted with the Nursing Home Administrator (NHA). The NHA indicated that physician orders and interventions should be followed.A review of a facility policy titled, Skin Management noted the following, .4. Residents admitted with any skin impairment will have: Appropriate interventions implemented to promote healing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record the facility failed to ensure medications were labeled and dated when opened in one of four medication carts. Findings include: On 09/22/2025 at 4:49 PM, the Spring Hill medication cart two was reviewed with Registered Nurse (RN) D. Two insulin lispro vials were not dated on the vial, for one active resident and one discharged resident, and a 100-50 MCG/ACT fluticasone-Salmeterol inhaler did not have a resident identifier, nor a date opened. On 09/24/2025 at 12:55 PM, the Director of Nursing (DON) reported the nurse should label the carton and the actual medication in case the carton is lost or damaged. A review of the identified medications on drugs.com documented: for the lispro insulin - Store the vial in a refrigerator or at room temperature and use within 28 days; and for the fluticasone/salmeterol - Write the date you opened the foil pouch in the first blank line on the label. Write the use by date in the second blank line on the label. That date is 1 month after the date you wrote in the first line.A review of the facility policy titled, Medication Management revised 09/22/23, revealed Medications are stored, dispensed and destroyed in a manner to ensure safety and conformance with state and federal laws .Medications will be dated and discarded per manufactures guidelines .