STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235733	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Troy	2685 West Maple Road Troy, MI 48084

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00148683. Based on interview and record review the facility staff failed to ensure all required documentation for a transfer to the hospital was documented in the medical record for one (R901) of three residents reviewed for a change of condition. Findings include: A review of a complaint submitted to the State Agency (SA) documented multiple concerns of negligent care provided by the facility that resulted in multiple hospitalization s. Review of the medical record revealed R901 was readmitted to the facility on [DATE], with diagnoses that included a fracture to the neck of the right femur. R901 was admitted for rehabilitation. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. Review of the progress notes revealed the following: A Nursing note dated 11/3/24 at 10:15 AM, documented hospitalized . A Nursing note dated 11/8/24 at 4:42 PM, documented in part . arrived via ambulance . admitted with IV (intravenous) ABT (antibiotic). Picc (Peripherally inserted central catheter) line to left upper arm . Physician aware of arrival . Further review of the progress notes revealed no documentation on what date R901 was transferred to the hospital and no documentation on the reason for the transfer. Review of a . Hospital Transfer Form dated 11/2/24, documented in part . Reason(s) for transfer - Abnormal X-ray . Tests: IV ABT . (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Transfer and Discharge revised 3/26/2024, documented in part . For circumstances under the criteria for transfer . the resident's physician or a non-physician practitioner (in accordance with State law) must document information on the basis of the transfer . The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility . The inability to meet the resident's needs, the documentation made by the resident's physician must include . The specific resident needs the facility could not meet. The facility efforts to meet those needs: and The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the facility . Review of the medical record revealed no findings of the required documentation for R901 transfer to the hospital. On 12/09/24 at 3:19 PM, the Director of Nursing (DON) was interviewed and was asked about the lack of documentation for R901's transfer to the hospital on 11/2/24. The DON was then asked why R901 was transferred to the hospital and to provide the radiology report that allegedly required the resident to be transferred. The DON stated they would look into it and follow back up. No further explanation or additional documentation was provided by the DON by the end of the survey. On 12/10/24 at 10:34 AM, during an interview conducted with the Wound Practitioner (WP) D, revealed they had received a call from R901's daughter who informed them that they were notified by the hospital of an abnormal microbiology report for R901. WP D stated they informed R901's daughter of a delay in getting an IV placed for IV treatment for R901 and the daughter felt more comfortable sending the resident out for treatment at the hospital. WP D was asked if they actually reviewed the culture report and if they could provide a copy to the surveyor due to the results not being maintained in the medical record. WP D stated the microbiology report was reported by R901's daughter after they reviewed R901's results via the hospital patient portal record. WP D was asked to provide the documentation noted in the medical record for R901 regarding the basis for the transfer to the hospital. WP D reviewed the chart and stated they were unable to find the documentation. WP D stated they thought they had documented the conversation in the medical record, however, was unable to provide the documentation. No further explanation or documentation was provided by the end of the survey.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00148683. Based on interview and record reviews the facility failed to timely identify, intervene, and notify the physician of a change in respiratory condition for one (R901) of three residents reviewed for a change of condition, resulting in the delayed care, delayed notification to the physician/practitioner and ultimately requiring a transfer to the hospital for a higher level of care. Findings include: A review of a complaint submitted to the State Agency (SA) documented concerns regarding negligence of the facility staff to have not identified R901's respiratory distress timely and concern of the facility staff to have ignored the abnormal respiratory respirations tracked by the facility's wall devices that monitor the residents vitals. The complainant noted in part . found her (R901) having immense difficulty breathing, using muscles in her chest, neck and abdomen to breathe. I went to get staff. They responded slowly to this emergent situation and took her oxygen level - it was between 70 & 76 . I directed them to call an ambulance . A review of the medical record revealed R901 was readmitted to the facility on [DATE] with a diagnosis that included a fracture to the neck of the right femur. Review of the 02 Sats (oxygen saturation levels) documented the following: 11/14/24 at 12:15 AM- 81% Room Air 11/14/24 at 8:52 AM- 85% Room Air Review of the medical record revealed no identification, interventions or notification to the physician made for the abnormal saturation levels. Review of a facility policy titled Notification Of Change revised 2/14/2024, documented in part . The facility must . consult with the resident's practitioner . when there is a change in status . A change in status would include the following . A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications . A need to alter treatment significantly . the licensed nurse will notify the resident attending practitioner. Any new orders or directives will be implemented by the licensed nurse . Changes in the resident status . The licensed nurse will document in the resident electronic medical record the notification and the information that was provided including any additional orders from the practitioner . On 12/9/24 at 3:13 PM, a telephone interview was attempted with Licensed Practical Nurse (LPN) B. This was the nurse assigned to R901 on 11/14/24 night shift when the 81% SPO2 level was noted. A message was left to return the call. The Director of Nursing (DON) was asked to get in touch with LPN B and have them return the surveyor's call for an interview for this investigation. The DON stated they would try to contact LPN B who was out of the country on vacation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes revealed the following: A Nurse Practitioner (NP) note dated 11/14/24 at 12 midnight documented in part . Pt (patient) hypoxic with SPO2 (oxygen saturation level) 85% (normal readings 90-100%) on RA (room air); oxygen was applied and duoneb tx (treatment) given. Pt currently 99% on 5L (liters) NC (nasal cannula), tachypneic (rapid breathing). Lungs with wheezing and coarse rhonchi. Pt denies [NAME] (difficulty in breathing) but does agree she is breathing more often than normal. +mild accessory muscle use. +cough, nonproductive but sounds like it should be . CXR (chest x-ray) pending, (radiology third party name) notified to change to stat (immediate) order. Later called back to room by nursing . XR (X-ray) tech at bedside for CXR. Worsening accessory muscle use . When asked if she was having difficulty breathing pt now replied Yes. CXR just completed, does appear to have some opacities but awaiting read. Pt and daughters at bedside now requesting to return to hospital . The time of the above practitioner note is not accurate as it is documented before the documented change of condition and was confirmed in the below interview with LPN C of the NP to have consulted with R901 on the day shift of 11/14/24 when they notified the NP who was in the facility of their concerns with R901. A Nurses note dated 11/14/24 at 1:27 PM, documented . Resident was transported by 911 . for respiratory distress per NP . This note was documented by LPN C. On 12/09/24 at 1:30 PM, a walk through observation of the facility revealed little devices observed above the resident beds for the purpose of monitoring the residents vital signs and alerting staff if abnormal findings are identified. On 12/9/24 at 2:47 PM, LPN C was interviewed and asked about the monitoring devices above the resident beds that monitor the resident vitals and how the system worked. LPN C stated the system was not working and was not being used by the staff. LPN C explained it was a new system and the facility haven't gotten it together yet. LPN C stated they obtain the residents vitals themselves. LPN C was asked if they were informed of R901's low oxygen saturation level of 81% at 12:15 AM on 11/14/24 when they arrived for their shift on the morning of 11/14/24 and received report from the off going nurse. LPN C stated they were not informed of the low oxygen saturation level by the off going nurse (LPN B). LPN C stated they were not aware of the low oxygen saturation for R901 until they were administering the morning medications and obtained R901 vitals themselves. LPN C stated once they identified the low level they informed the NP who ordered to give a nebulizer treatment to the resident. LPN C stated they also applied oxygen to R901. LPN C stated R901 was sent to the hospital at the family's request. Review of the nebulizer order documented an order date of 11/14/24 at 11:16 AM. This is 11 hours after the abnormal oxygen saturation level for R901 was first noted. Review of the medical record revealed no order for supplemental oxygen to be administered to R901. The record revealed R901 did not return to the facility after being transferred to the hospital on 11/14/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 3:19 PM, the Administrator was interviewed and asked about the wall devices in the resident rooms that monitor the resident vitals and if they were operable. The Administrator stated the devices are ran by a third party company that will send the facility alerts when anything is abnormal. The Administrator replied that the system was operable and currently being utilized. On 12/9/24 at 3:26 PM, during an interview with the Director of Nursing (DON) the DON stated the wall devices are still being worked on and was currently not being used in the facility. The DON explained that the alerts are only sent to themselves and the Administrator. The DON stated the floor staff are unable to see the alerts. The DON stated if anything is identified as abnormal they would have to inform the floor staff of the findings. The DON was asked if the devices monitored pulse oxygenation or respirations and the DON stated the devices do not monitor the oxygenation level but do monitor the respiration levels. The DON was asked if they received an alert on 11/14/24 regarding any abnormal vitals for R901 and to provide all documented vitals recorded by the device from the third party company. The DON stated they would look into it and follow back up. The documented SPO2 levels were reviewed with the DON. The DON was asked their expectation of the staff from the first recorded SPO2 level of 81% on room air on 11/14/24 at 12:15 AM. The DON replied they would expect for the nurse to apply oxygen to the resident and notify the on call clinician. The DON was then asked about the delayed identification of the abnormal oxygenation level from 12:15 AM, with no interventions, treatments or notification noted until the documentation of the nebulizer treatment at 11:16 AM, eleven hours later for a resident experiencing respiratory distress. The DON stated they would look into it and follow back up. On 12/10/24 at 8:37 AM, the DON stated they were able to briefly communicate with LPN B who is currently on vacation in another country in a remote area. The DON stated that LPN B would attempt to return the surveyors call before the end of the survey. A call was not received by LPN B before the end of the survey. No further explanation or documentation was provided by the end of the survey.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00148683. Based on interview and record reviews the facility failed to consistently implement and apply wound treatments as ordered by the practitioner timely, failed to consistently identify and report worsening of the wound to the Wound Practitioner (WP) and failed to document clinical reasons and/or justification for the change of an antibiotic treatment, and the delayed/missed IV (Intravenous) and oral antibiotics for a wound infection, for one (R901) of three residents reviewed for wounds, resulting in delayed and omitted treatments and transfers to the hospital for higher level of care. Findings include: A review of a complaint submitted to the State Agency (SA) documented concerns of the facility's failure to provide adequate and appropriate care to prevent and care for an infected pressure wound. Review of the medical record revealed R901 was readmitted to the facility on [DATE] with a diagnosis that included a fracture to the neck of the right femur and required staff assistance for all activities of daily living (ADLs). Review of a Nursing summary note dated 10/10/24 at 7:29 PM, documented in part . admitted from (hospital name) with DX (diagnosis) of Left Femur fracture . Wounds to spine . A Skin & Wound Evaluation dated 10/10/24 with a lock date of 10/15/24, documented in part . Pressure . Stage 3: Full-thickness skin loss . Spine . Area 7.5 cm2 (centimeters squared) . Length 5.7 cm (centimeters) . Width 3.7 cm . Depth < 0.1 cm . % Slough 50% . Healable . Review of the physician orders documented, . Cleanse spine with wound cleanser, apply honey calcium alginate and cover with foam, every night shift, every two days . A duplicate as needed (PRN) order was also implemented, both with the start date of 10/11/2024. A review of a Wound consultation dated 10/15/24, documented in part . has wound on her upper back with slough present. Continue medihoney and calcium alginate . Cleanse spine with wound cleanser. Apply medihoney and calcium alginate. Cover with a foam border. Change every other day and prn (as needed) . Location: spine . Stage: stage Three . Review of the October 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the treatment to the spine was not applied on 10/21 or 10/23/24. The medical record was reviewed and revealed no documentation on why the treatment was not applied to the spine wound. On 10/25/24 a wound consult revealed the worsening of the spinal wound. Review of the consult documented mild odor from the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 a wound consult documented in part, . Patient has a wound on her spine. Patient wound has become worse . Daughter was educated on the plan of care of patient. Daughter was agreeable but would still like to send her to the ER (emergency room). Patient was sent to the ER per family request . Review of the medical record contained no documentation of the front line staff (nurses and aides) to have identified the worsening of the wound and no notification to the physician of the wound worsening. The worsening of the wound was not identified or noted until examined by the Wound Practitioner on their weekly rounds. A review of the Emergency Department (ED) provider notes dated 10/29/24, documented in part . Patient presents with Wound Infection . recommended that they stay for wound care, IV antibiotics and some concern that could be component of infection and evaluation by neurosurgery. The patient states that she is not wanting surgical treatment, does not want to stay in the hospital . Clinical Impressions . Pressure injury of skin of right lower back . Cellulitis of upper back . cephalexin (Keflex- antibiotic) 500 mg (milligram) capsule . Take 1 capsule . by mouth 3 . times a day for 7 days . Review of a Blood culture report collected at the hospital on 10/29/24 at 3:01 PM, documented . Culture in progress . Gram positive cocci in chains . Growth only in the aerobic bottle of this set. 1 set positive/1 set drawn . R901 was discharged from the hospital and their readmission was accepted by the facility. Review of a Nurse Practitioner (NP) note dated 10/30/24, documented in part . Pt (patient) returned from the ED for wound eval (evaluation). Pt returned with rx (prescription) Keflex 500 mg TID (three times a day) x7 days . Pt was given 1g (gram) Rocephin IV. Pt was recommended admission by ED MD (Medical Doctor) for IV abx and neurosurgery eval, however pt states she does not want surgical tx (treatment) or to stay in the hospital . Continue with PO (by mouth) Keflex course. Continue current wound care tx . Review of the October 2024 MAR revealed the Keflex was administered on 10/30/24 and 10/31/24. Review of the November 2024 MAR documented that the Keflex was stopped on 11/1/24 after the 2 PM dose (two doses total for the day). A new order for Clindamycin HCL 300 mg capsule to be given every six hours for 10 days was ordered on 11/1/24. Review of a Wound Practitioner note dated 11/1/24, documented in part . Chief Complaint - Wound . seen for wound care. Daughter called [NAME] with concerns of wound care bacterial infection. Daughter states patient wound cultures have resulted from her recent hospitalization . Wound cultures came back positive for gram positive cocci. Clindamycin has been ordered 300 mg every 6 hours . Orders for STAT x-ray to rule out osteomyelitis . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed no results of a culture and sensitivity test obtained from the positive culture report from the hospitalization (the culture and sensitivity test would have revealed which antibiotics the bacteria was sensitive or resistant to). An additional review of the medical record revealed no identification of the wound cultures or worsening of the wound by the facility staff. The Wound Practitioner was notified by R901's daughter as noted of the wound culture results. There was no documentation noted in the medical record on why the antibiotic was changed from the hospital ordered antibiotic Keflex to the Clindamycin on 11/1/24. Review of the medical record revealed an ER (emergency room) hospital document with an Encounter Date: 10/29/2024 and a fax transmittal date of 10/30/2024 at 1:00 PM, of an abnormal blood culture result that noted Gram positive cocci in chains however also noted . Culture in progress . The facility was aware of the abnormal culture result on 10/30/24, with no documentation noted of the identified abnormal culture report or notification to the physician and/or practitioner. Review of the November 2024 MAR revealed the resident did not receive the newly ordered Clindamycin dose on 11/1/24 at 6 PM, 11/2/24 at 12 midnight or 6 AM as ordered by the Physician. This indicated that the resident missed three doses of the newly ordered antibiotic. Review of a Hospital Transfer Form dated 11/2/2024, revealed the resident was transferred to the hospital for an Abnormal X-ray. There was no documentation of an explanation of the X-ray results or why the resident had to be transferred to the hospital noted in the medical record. Review of the hospital documentation for the dates of 11/2/2024 through 11/8/2024 hospitalization , documented in part . presents to the emergency room from (facility name) with large pressure ulcer wound mid back and positive blood cultures . Several days ago there were blood cultures and wound cultures taken which came back positive so she was brought back to the hospital for admission for IV antibiotics . 11/7/2024 . Power PICC Solo Insertion Procedure Note . Indications: Long Term IV therapy . plan for 4 weeks of vanco, cefepime, Diflucan therapy . inserted into right PICC VEIN . Review of a hospital After Visit Summary with the dates of 11/2/2024 - 11/8/2024, documented in part . Wound infection . START cefepime 1 g (gram) in sodium chloride 0.9% 50 ml (milliliters) IVPB (Intravenous Piggy Back) Infuse 1 g into a venous catheter every 12 (twelve) hours for 23 days. End date: 12/1/24 . START vancomycin 500 mg in sodium chloride 0.9% 100 ml IVPB. Infuse 500 mg into a venous catheter 1 (one) time each day at the same time for 23 days. End date: 12/1/24 . Review of a hospital document provided to the facility Pharmacy to Dose - vancomycin - IV ONLY dated 11/7/24, documented the resident received their IV vancomycin on 11/7/24, however the 11/8/24 dose was canceled due to the resident being discharged back to the facility. Review of a hospital prescription provided to the facility dated 11/8/24 documented in part, . vancomycin 500 mg in sodium chloride 0.9% 100 ml IVPB . Infuse 500 mg into a venous catheter 1 (one) time each day at the same time for 23 days. End date 12/1/24 . Start: Nov, 8, 2024 . Review of the medical record documented R901 was readmitted back to the facility on [DATE]. Further review of the medical record revealed R901 did not receive their 11/8/24 vancomycin dose at the facility. An additional review of the medical record revealed no documentation from the Nurse, Practitioner or Physician to have identified, clarify or explain why R901 did not receive their 11/8/24 IV Vancomycin dose. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a wound consult dated 11/10/24 documented in part, . being seen for wound care . Daughter called [NAME] with concerns of wound care bacterial infection . Patient on IV ABX currently. New wound orders placed. Cleanse spine with wound cleanser. Apply dime thickness triad to base, Pack with MESALT packing strip , cover with gauze and cover with foam x2 daily and PRN . Review of the medical record revealed no documentation of staff to have identified changes or concerns with R901's wound and again noted R901's daughter to have contacted the WP with their concerns. Review of the November 2024 MAR and TAR documented the following order noted above from the practitioner was implemented two days later on 11/12/24 and completed once then started on 11/13/24 as ordered. This indicated a two day delay in implementing the treatment prescribed by the wound practitioner with no documentation in the medical record on why the treatment was delayed. A nursing note dated 11/14/24 at 1:27 PM, documented the resident was transferred to the hospital for respiratory distress via 911. The resident did not return back to the facility. On 12/9/24 at 3:26 PM, the Director of Nursing (DON) was interviewed and asked the facility protocol with rounding with the Wound Practitioner when they come to the building and the implementation of any modified or ordered treatments. The DON explained that the facility's wound nurse had retired and the facility had recently hired someone for that role. The DON stated the wound nurse would round with the physician but they were unsure of how the orders were implemented and would look into it and follow back up. The DON was then asked about R901's missed wound treatments for the dates of 10/21/24 and 10/23/24 the DON replied they would look into it and follow back up. The DON then stated they along with the previous wound nurse talked to R901 and their family extensively regarding the concerns of lack of intake and the wound decline. The DON was informed to provide all documentation for review. On 12/10/24 at 9:13 AM, a follow up interview was conducted with the DON. The DON stated when the previous wound nurse retired, the floor nurses were rounding with the Wound Practitioner. The DON explained that the new wound nurse hadn't received access to the facility's electronic medical system at the time, which was the reason the floor nurses were rounding. The DON stated they believed the practitioner put in their own orders but would have to clarify. The DON was asked the expectation of the facility staff if they identified the worsening of a wound and the DON replied the staff should be notifying the wound nurse, themselves (DON) and not waiting for the wound practitioner to round. The DON was asked why R901's antibiotic (Keflex) prescribed by the hospital on 10/29/24 for seven days was discontinued on 11/1/24 and changed to Clindamycin. The DON was informed of the medical record to have been reviewed with no findings of a culture and sensitivity report on file for the abnormal blood culture report. The DON was asked to provide the report to the surveyor for review. The DON stated they would look into it and follow back up. The DON was asked about the delayed/missed doses of the ordered Clindamycin and the DON replied they believed they have that particular antibiotic in the facility's back up system but would check and look into it. The DON was asked why the resident was transferred to the hospital on 11/2/24 and the DON stated they would look into it. The DON was then asked about the missed IV antibiotic dose on 11/8/24 as ordered by the hospital, asked about the delay in implementing the wound treatment ordered by WP D on 11/10/24 and asked about the lack of staff identification of the wound worsening of the wound and notification to the physician. The DON stated they would look into the concerns and follow back up. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/24 at 10:34 AM, Wound Practitioner (WP) D was interviewed and asked about the Keflex to Clindamycin change on 11/1/24 and if they knew the reason R901 was transferred to the hospital on 11/2/24. WP D stated they had changed the Keflex to Clindamycin on 11/1/24 because they had talked to R901's daughter and they had asked the daughter about what medications R901 had taken in the past. WP D stated R901's daughter informed them that R901 had been on Keflex in the past. WP D explained they did not want R901 to become resistant to the Keflex so they changed the Keflex to Clindamycin based on R901's daughter to have informed them that R901 was on Keflex for a long time in the past and had never been put on Clindamycin. WP D was asked if they had reviewed the culture and sensitivity results of the blood culture before changing the antibiotic and WP D replied they had not reviewed the report. WP D stated the daughter informed them that they had reviewed the culture results via the hospital portal medical record and informed them of the findings. WP D then stated they informed R901's daughter that the chances of getting an IV team to come in for placement for IV antibiotics may take . a very long time . WP D stated they informed R901's daughter that if they felt more comfortable they could send R901 out to the hospital for .treatment right away . When asked about the identified worsening of the wound and who they were notified by, WP D stated as documented they were notified by R901's daughter. On 12/10/24 at 11:55 AM, a follow up interview was conducted with the DON. The DON stated the reason the IV antibiotic was not given on 11/8/24, is because it was due at 2 PM and the resident was not readmitted until after 5 PM on 11/8/24. The DON was asked despite the hospital informing the facility that the IV antibiotic was not given on 11/8/24 and instructed the facility to administer the 11/8/24, they did not administer it? The DON confirmed that to be true. The DON was asked why there was no documentation in the medical record from the admitting nurse or any other nurse noting that the physician was informed of the orders and directive of the hospital physician on readmission. The DON stated the nurses send a message to the physicians on every admission. The DON was asked to provide any documentation of the nurses to have identified and notified the physician of the facility to have had a discussion regarding R901's 11/8/24 IV antibiotic dose. The DON stated Clindamycin is supplied in the facility's back up box if needed and was unsure on why it was not administered timely. The DON stated they reviewed the notes and was unable to find supporting documentation. The DON stated they were unable to locate the culture and sensitivity report but would see if they could pull it. The DON stated they were unable to find additional documentation or information regarding the missed and delayed treatments. No further explanation or documentation was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235733	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Troy	2685 West Maple Road Troy, MI 48084

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41415 This citation pertains to intake: MI00148683. Based on observation, interview and record reviews the facility failed to ensure the kitchen staff followed proper procedures for sanitation and food storage, this had the ability to affect all 78 of 78 residents that resided in the facility at the time of the survey. Findings include: On 12/9/24 at 8:30 AM, a kitchen tour was conducted with Certified Dietary Manager (CDM) A. Upon observation in the refrigerated food storage was a large white tub of ricotta cheese with the top ajar with no open date noted. When asked about the tub, CDM A stated it was not dated because it was not opened yet. CDM A was asked to lift the top of the ricotta which revealed a plastic film fully ripped off the tub of ricotta. This indicated the ricotta tub had previously been opened. On the top shelf of the refrigerated storage area stored with food was an insulin pen with CDM A's name noted on the pen. CDM A was asked if the insulin pen belonged to them and they confirmed that it did. CDM A was asked why they stored their insulin pen on the shelves with the resident's food and CDM A replied they had nowhere else to store it. Observation of the dry food storage area revealed an open pasta bag that was not dated and an employee cellphone charging on the shelf with the residents food. Further review of the kitchen revealed an opened butter sitting on the counter top, not dated and not in use. A jar of grits opened and not dated was by the butter. Wet spots noted on the floors and counter tops with a glove noted on the floor of the kitchen. Observed hanging on the wall was the cleaning schedule for the kitchen. Review of the cleaning schedule noted the last date completed was November 30, 2024. CDM A was asked how they ensured that all areas were clean from December 1st to current (12/9/24) if the cleaning schedule was not implemented for December. CDM A stated it was their responsibility to ensure the cleaning schedule is implemented monthly and they had not done it yet. CDM A was asked to provide the policy for kitchen sanitation and proper food storage. On 12/9/24 at 9:20 AM, the Administrator was interviewed and asked about the above findings and stated they would usually do rounds in the kitchen every morning with CDM A, however this morning due to the start of the survey they had not conducted the round yet. When asked, the Administrator stated CDM A should not store their insulin in the residents refrigerator and staff should not charge their phones in the dry food storage area. A facility policy was provided regarding the kitchen sanitation and reviewed, however revealed no guidance for the above concerns identified. No further explanation or documentation was provided by the end of the survey.