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	08/21/2025

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This complaint pertains to complaint 2587774Based on interview and record review facility failed to ensure timely admission orders were implemented for one (R901) of two residents reviewed for admission orders resulting in the potential for residents to not receive timely care/services with potential for decline in their health condition and avoidable hospitalization. Findings include:R901A complaint received by the State Agency revealed that R901 was admitted to the facility for recovery after hospitalization and did not receive care/services as ordered by the hospital for hours after admission to the facility. R901's family had to transport the resident back to the hospital late at night (around midnight) as they were upset with the care/services that were not provided timely after admission to the facility. The report further revealed that the complainant had filed a police report after they were informed (over the phone) by a facility staff member that they were unable to find the nurse assigned to care for R901 for an extended period of time, when the complainant had called to check on their family member.Record review revealed R901 was admitted to the facility on [DATE] from hospital with primary diagnosis of acute hypoxic respiratory failure. R901 was living at home, and they were admitted to the hospital on [DATE] with a respiratory failure. R901's admitting diagnoses also included lung cancer, anxiety, Seizure disorder, and atrial fibrillation. R901 was also scheduled to receive out-patient radiation therapy at the hospital.Review of R901's discharge summary from the hospital dated 8/8/25 revealed that R901 was living at home with their spouse prior to admission to hospital and they were independent with their mobility and Activities of Daily Living (ADLs) at home, and the plan was to return home with their spouse. R901 was admitted for short-term skilled nursing and rehabilitation care.R901's discharge orders revealed that they received continuous oxygen therapy 3 liters/minute via nasal canula. A pulmonologist note dated 8/1/24 revealed that R901 had stage 3 lung cancer and concerned with the degree of breathlessness. A neurology consult note dated 8/7/25 revealed that R901 was alert, oriented to person, place, month, and year. Review of communication activity notes between the hospital discharge planner and facility admission representative revealed that R901's information were sent over to the facility on 8/7/25 and they had accepted R901's admission to facility on 8/8/25 at 1:30 PM. Review of R901's Electronic Medical record (EMR) revealed a nursing progress note dated 8/8/25 that read in part, patient arrives 6:10 pm via wheelchair.Review of R901's discharge orders from the hospital revealed the following orders for medications were scheduled to be administered at bedtime:1. Amoxycillin 500 MG (milligrams) - Take 1 capsule 3 times daily for 6 days (Morning, Evening and Bedtime)2. Apixaban 5 MG Tablet - Take 1 tablet by mouth 2 times daily (Morning and Bedtime) - last time given on 8/8/25 at 8:06 AM3. Diltiazem 60 MG - Take 1 tablet 3 times daily for 6 days (Morning, Evening and Bedtime) - Last time given on 8/8/25 at 8:07 AM4. Metoprolol Tartrate 100 MG - Take 1 tablet by mouth 2 times daily (Morning and Bedtime) - Last time given on 8/8/25 at 8:07 AM5. Omega-3 acid ethyl [NAME] - Take 1 tablet by mouth 2 times daily (Morning and Bedtime) - last time given on 8/8/25 at 8:06 AMR901 also had orders for PRN (as needed) medications that included cough medications, inhalers, pain medications, and medication for anxiety. Review of R901's EMR did not have any admission medication orders that were ordered from the hospital. R901 did not have any order for oxygen therapy. Further review of R901's EMR did not reveal any admission nursing assessment form. A nursing progress note dated 8/8/25 at 23:06 (11:06 PM) read in part, Resident's daughter stated that she called the facility to retrieve information about her mother at 17:30 (5:30 PM) and was on hold for 25 minutes. Then her call was rerouted to the receptionist. Resident daughter stated that the receptionist told her that the floor never answers their calls. daughter states that she asked the receptionist if she should call the police and alleged that the receptionist response was 'I would if I were you'.A progress notes at 23:29 (11:29 PM) read, vitals were requested from resident daughter because resident stated that she did not vitals upon arrival. It must be noted that R901's EMR did not have any other vitals. It read 147/72 BP (blood pressure), 97% O2 (oxygen) saturation with 3L (liters) of O2 (there was no physician order). A nurses note at 23:43 revealed that family took R901 from facility Against Medical Advice (AMA).An interview with the complainant was completed (via phone) on 8/20/25 at approximately 4:30 PM. During the interview, R901's daughter confirmed all the concerns as above and reported that they took R901 back to hospital from the facility around midnight. They reported that transportation picked up their mother around 5:30 pm on 8/8/25 from the hospital. R901's daughter added that they lived far from the facility. They were unable to get hold of the nurse to get a report on how her mother was doing and decided to drive to the facility late at night. The

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This complaint pertains to complaint 2587774 and 1361575.Based on observation, interview, and record review facility failed to ensure nursing professional standards were consistently followed for two (R907 and R910) of two residents reviewed for nursing standards, when staff failed to reconcile the medication orders for R907 for an extended period; and failed to administer timely as ordered and document medication administration for R910. This deficient practice has the potential for adverse effect/interaction from improper dose/time and overall decline in health condition with/without avoidable hospitalization. Findings include:R910 Record review revealed R910 was originally admitted to the facility on [DATE]. R901’s admitting diagnoses included left radius (forearm) fracture and right humerus (upper arm bone) fracture from a fall and recent (outpatient) surgery on the left forearm on 8/15/25, anxiety disorder, high blood pressure, heart failure, and aortic stenosis (narrowed or stiff heart valve making it hard for the valve to open fully and limiting blood flow from the heart to the body) and recent heart surgery. Based on Brief Interview for Mental Status assessment (BIMS) dated 8/14/25, R910 had BIMS score of 15/15, indicative of intact cognition. R910 was able to bear any weight on both arms due to recent fracture. An initial observation was completed on 8/20/25 at approximately 10:45 AM. R901 was observed in a wheelchair outside their room. They had a large bulky bandage that covered almost the entire length of their left forearm, they were trying to use their feet to propel the wheelchair and asking for help. When they were asked what happened and if they needed any assistance, R901 reported that they needed their pain medicine, and they added that they had not received any of their morning medication. They added they fell and broke both arms. R910 stated “I cannot move arm…it is so painful” and “I cry like a baby”. When asked to rate the pain on a 0-10 scale (0-no pain and 10 – worst/very severe pain) R910 rated their pain as 7/10, and they needed their pain medications. There was no nurse in the hallway. At approximately 10:55 AM, a nurse LPN (Licensed Practical Nurse) LPN “F” was in the hallway near room [ROOM NUMBER] and they were queried if they were assigned to care for R910 as they were waiting for their pain medications. LPN “F” reported that the other nurse LPN “G” was covering the rooms, and they were in the other hallway. At approximately 11:05 AM, LPN “G” was observed coming towards the end of the hallway. They were notified that R910 was in pain, and they were waiting for their medications. LPN “G” reported they just finished their hallway, and they would go and assist R910. Review of R910’s Electronic Medical Records (EMR) revealed that the following medications were ordered for R910 to receive in the morning: Alendronate Sodium 70 mg (milligram) on time a day every Sunday at 6 AM for bone density Breo Ellipta inhalation aerosol one time a day for COPD (Chronic Obstructive Pulmonary Disease) at 9 AM Ergocalciferol 50000-unit one capsule one time/day every Sunday at 9 AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fluticasone Propionate suspension 50 MCG (microgram) two spray in both nostrils one time /day at 9 AM Lidoderm patch 5% to the affected area for pain the morning at 9 AM Lisinopril 20mg 1 tablet one time a day for hypertension (high blood pressure) at 9 AM Metoprolol Succinate Extended Release 25 MG (milligram) one tablet one time a day at 9 AM Paroxetine 20 MG one tablet one time a day 6 AM Polyethylene glycol power 1 scoop one time a day for constipation at 9 AM Sennoides 8.6 mg tablet one time a day at 9 AM Acetaminophen 325 MG 2 tablets every 6 hours as needed for general discomfort Hydrocodone-Acetaminophen 7.5-325 MG 1 tablet very 6 hours as needed for pain Methocarbamol 500 MG one tablet every 12 hours as needed for pain Tramadol 50 MG one tablet every 8 hours as needed for pain Further review of Medication Administration Record at approximately 11:30 AM did not reveal that R901 had received any of their scheduled morning medications that were ordered to be administered at 6 AM and 9 AM and any of their as needed (PRN) pain medications. An interview with LPN “F” was completed on 8/20/25 at approximately 10:55 AM. They were observed to start passings the meds in hallway where R910 was residing. They were queried if they were able to pass medications to their residents as ordered. LPN “F” reported that they were still passing morning medications; they were an hour late and they still had many residents to go. They added we could use another nurse. When they were asked if that was an isolated incident today, they reported “no” and added that was their regular schedule. An interview with LPN “G” was completed at approximately 2:45 PM. They were queried if they were able to complete all their medication administration tasks timely as ordered and they stated “no”. They reported that they had high acuity residents with tube feeding, wounds etc. and they needed a 3rd nurse to assist them. They were queried about R910’s morning medications and when they had administered and if they had given her pain medications. They reported that 910’s medications were administered late, around 12:20 PM including the pain medications. An interview with Unit Manager (UM) “H” was completed on 8/21/25 at approximately 10:56 AM. They were queried about the medications that were administered late for R910 and other residents and if the nurses were able to administer the medications as timely. UM “F” reported that they had two nurses, and it was dependent on the nurse and what went on during that shift. Some nurses needed additional time, and they were doing their best to assist and support them. When queried about R910 receiving their morning medications after 12 PM they agreed it was concern. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview with UM “H” at approximately 2:20 PM they were asked to check the EMR for the medication (morning) administration time for R910 on 8/20/25 as surveyors did not have access to the time. UM “H” reported that R910 received all their morning medications in 8/20/25 at 12:26 PM. When queried if R910 received the PRN pain medications as they did not mark as given on the Electronic Medication Administration Record (EMAR). UM “H” confirmed that they were not marked as given on EMAR and obtained the narcotic disposition book. The narcotic disposition sheet revealed that R910 received: Tramadol 50 MG on 8/20 at (?) 12 PM (time written was not clearly legible) and Hydrocodone 7.5/325 MG at 16:00 (4 PM). They were both administered by LPN “G”. When UM “H” was questioned about the facility process and the discrepancy between the EMAR and the narcotic disposition record they reported that both records should match, and LPN “G” must have forgotten to sign out on EMAR. They added that they understood the rationale for the concern and would follow-up with their Director of Nursing (DON). An interview with Director of Nursing (DON) was completed on 8/21/25 at approximately 3 PM. They were asked to explain the facility process to ensure timely medication administration for their residents and the documentation expectations for medication administration. The DON reported that scheduled medication could be administered one hour prior or one hour after the scheduled medication administration times and the nurses are expected to document the medication administration on the EMAR. When queried about discrepancy of narcotic disposition record and the EMAR they reported that they both should match. They were notified of the concern for R910, and they reported that they understood the concern. The DON later provided a sign-in sheet for a staff meeting and an agenda dated 8/18/25 and stated that they were in the process of streamlining the medication administration process/times. R907 Clinical record review revealed R907 was admitted to the facility on [DATE] for ongoing physical rehabilitation and medical management status post a fall at home that required hospitalization for treatment of a spinal cord injury and underwent a spinal arthrodesis (surgical procedure that permanently fuses bones together). R907 was alert, orientated and capable of making their needs known. The Brief Interview of Mental Status (BIMS) assessed on 5/23/25 scored 15/15 indicating R907 was cognitively intact. Findings include: A complaint was received to the State Agency alleging R907 did not appear themself, was lethargic and concerned they were over medicated with pain medication. On 8/22/25 at 10:00 AM, Unit Manager Registered Nurse (RN) “B” was asked to explain the admission process for residents’ medication orders. RN “B” explained the first medication reconciliation is performed by a charge nurse who reviews the hospital After Visit Summary (AVS), manually enters the medications into the computer then uploads. The Provider is notified there are orders for review, and an additional reconciliation is performed by the Unit Mangers the following day. RN “B” said the Medical Director will come to see the newly admitted resident then also verify orders. RN “B” was questioned if Oxycodone (narcotic medication to treat pain) is typically ordered around the clock for residents who are also receiving scheduled pain relief medications, RN “B” quickly responded “no” because the resident is here for rehab and you don’t want them “…to be snowed…” Oxycodone is typically only ordered as needed for break through pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the AVS for pain medications was reviewed and documented to continue the following for narcotics for pain: “…Take this medication as needed…” Oxycodone 5 mg Immediate Release (IR) 1 Tablet by mouth every 4 hours “…as needed…” for Moderate/Severe Pain. On 5/16/25 at 11:39 PM, Licensed Practical Nurse (LPN) “D” created and confirmed Oxycodone Tablet 5 mg give 1 tablet by mouth “…every four hours…” for moderate to severe pain. On 5/17/25 at 12:04 AM, Nurse Practitioner (NP) “C” documented a Telehealth Visit Detailing a seven-day prescription for Oxycodone and Methadone were sent to the pharmacy. Review of the Controlled Drug Receipt/Record/Disposition Form from the pharmacy documented Oxycodone 5 mg 1 tablet by mouth every four hours “…as needed…” for pain. Nursing documented administering Oxycodone “…every four hours…” regardless of R907 reporting a zero out of ten-pain score (pain scale used to measure and manage pain. Zero is no pain, Ten is severe pain). The Medication Administration Record (MAR) documented Oxycodone Tablet 5 mg give 1 tablet by mouth “…every four hours…” for moderate to severe pain. Start Date: 5/17/25 01:00 and Discontinue 5/23/25 at 12:28 PM. Reorder of the Oxycodone medication was placed on 5/23/25 by the Medical Director documenting Oxycodone 5 mg tablet. Directions: 1 Tablet by mouth every four hours “…as needed…” for pain. The MAR documented the reorder to start (5/23/25) Oxycodone 5 mg give 1 tablet by mouth “…every 4 hours for Pain…” Record review of the Physician's History and Physical dated 5/18/25 documented “…Multimodal pain control with scheduled Tylenol, Robaxin, methadone and PRN (as needed) Oxycodone for severe pain Record review of a Physician Note from 5/19/25 at 16:20 documented to continue Oxycodone 5 mg every 4 hours “…as needed…” On 8/21/25 The Medical Director and Director of Nursing (DON) were present for an interview to review R907’s MAR ordered pain regimen which included the following: Methadone (long-acting narcotic pain reliever) 5 mg 1 tablet every 12 hours for pain management Acetaminophen (pain relieve) 325 mg 2 tablet every 6 hours for pain management Methocarbamol (muscle relaxer) 750 mg 1 tablet every 6 hours for muscle spasms Oxycodone (fast-acting narcotic pain reliever) 5 mg 1 tablet every 4 hours for moderate to severe pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When the Medical Director was questioned if ordering Oxycodone around the clock every four hours in conjunction with the methadone, acetaminophen and methocarbamol is normal for a resident sent for rehabilitation, the Medical Director replied it is ordered if it is needed. When questioned if R907 had reported a pain score of zero, should the medication still be given? The Medical Director replied “No”. The Process for R907’s Oxycodone orders and administration were further discussed with the Medical Director and DON which identified on date of admission 5/16/25 at 11:39 PM. LPN “D” created and confirmed the Oxycodone 5 mg give every four hours was not correct and should have been scheduled as needed. The DON was asked if the Controlled Drug Receipt/Record/Disposition Form labels with documented Oxycodone 5 mg 1 tablet by mouth every four hours as needed for pain should be compared to what is on the MAR, the DON said yes and identified Nursing was not comparing the two orders in which one was prescribed as giving Oxycodone every four hours and the correct order from the Medical Director was written to administer as needed, and the error should have been caught. The DON acknowledged Nursing was not reviewing the Oxycodone medication prior to administering and Nursing did not transcribe the Physician orders correctly. Review of the facility policy titled; Physician’s Orders dated 8/2025 documented: “The licensed nurse receiving the order must verify to ensure the order is complete and that it includes: …Accurate frequency…”

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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. This intake pertains to intake # 2587857.Based on observation, interview, and record reviews, the facility failed to properly label, and date opened insulin pens for two of two residents (R911 and R912) reviewed for medication storage, resulting in insulin pens being mixed up and the potential to administer the incorrect insulin to a resident and adverse reactions. Findings include:Complaint 2587857On 8/20/25 at approximately 9:19 AM, an observation of the Maple East cart was made and a review of insulin was made with the Unit Manager B and Nurse L. It was noted that R911 had a Lantus insulin pen with their name on it but the insulin pen was in a bag with R912's name on it. The medication cart also had a total of 6 insulin pens with no date of when they were opened. An interview was conducted at the same time the medication cart was observed with Unit Manger B and Nurse L, they were asked about the residents' insulin that was in the incorrect resident's bag and should insulin pens be dated upon opening. Nurse L reported that the medication should have been labeled for the appropriate resident and that insulins should be dated once they are opened. Nurse L reported that they had just started the use of insulin pens verses the vials and that they would start putting an open date on them.No additional information was provided by the exit of survey.