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	02/02/2026

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 0689 Level of Harm - Actual harm 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: 2709710.Based on interview and record reviews the facility failed to implement adequate/effective fall interventions and ensure consistent follow up of fall interventions implemented, for one (R201) of one resident reviewed for falls. This resulted in a transfer to the hospital and the identification of a left ischium fracture. Findings include:A review of a complaint submitted to the State Agency (SA) documented in part . (R201's name) had multiple falls at (facility name). suffered a . left leg fracture. on 1/3, a nurse. and her. nurse manager at (facility name) refused to call 911.A review of the hospital referral provided to the facility upon R201's admission documented the following in part, . Hospital Problem List - Open fracture of nasal one, initial encounter. Nasal septum fracture. Nasal laceration. Fracture of fingers, left. Fall. Syncope and collapse.A History & Physical dated 12/9/25 at 10:38 AM, documented in part . presents to the Emergency Center for a fall injury. Mechanical fall falling forward hitting his face. He broke his dentures, He has a nasal injury. Has swelling and bruising surrounding the left pinky. He is complaining of left arm pain.A Otolaryngology Consultation dated 12/9/25 at 8:35 AM, documented in part . nasal bone fractures. along with anterior superior nasal septum fracture. In the ED (emergency department) they sutured his nasal dorsal laceration with nylon suture.A review of the medical record revealed R201 admitted to the facility on [DATE], with diagnosis that included: dementia, alzheimer's disease, falls, major depressive disorder, glaucoma, and fracture of the nasal bones. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 03, that indicated severely impaired cognition and required staff assistance for all Activities of Daily Living (ADLs). A review of a care plan titled . impaired communication r/t (related to) has some confusion and his primary language is Arabic as evidenced by Confusion, Language barrier.A review of an admission fall assessment dated [DATE] at 2:36 PM, documented the resident Category: No Risk. Score: 9.0. A fall care plan was implemented from this assess with the following interventions, . Encourage the resident to wear appropriate footwear as needed, Keep the resident's environment as safe as possible with: even floors free from spills and/or clutter; adequate lighting; call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate position, PT (physical therapy)/OT (occupational therapy) evaluate and treat as ordered or PRN (as needed), Provide resident with activities that minimize the potential for falls while providing diversion and distraction, Put the call light within reach and encourage him/her to use it for assistance as needed.A review of the medical record revealed the following:On 12/12/25 at 7:59 PM, a Nursing note documented . Writer was notified by CNA (certified nursing assistant) that resident was on the floor. Writer entered the room and observed the resident sitting on his bottom by the left side of his bed. Resident stated that he was trying to reposition himself in the bed and then fell to the floor. no new injuries.On 12/13/25 at 7:24 AM, a Nursing note documented . Resident confused. Constantly (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 - Actual harm Residents Affected - Few	sliding himself out of bed and onto floor.On 12/13/25 at 9 AM, a Telehealth encounter note documented . Change in elevation encounter. Unwitnessed. Resident was found down. Resident observed lying on back, on bedroom floor, on the side of the bed, with pillow under head. No other injuries.On 12/15/25 at 3:16 PM, a Nursing note documented . IDT (interdisciplinary team) reviewed fall on 12/12/23 no injury, root cause daughter states he told her, he dropped his book on floor and attempt to pick it up resulting in fall. Care plane <sic> reviewed and updated for therapy to assess for assist bars to increase bed mobility and reacher for hard to reach items.A review of the medical record and Physical & Occupational therapy notes revealed the resident was never assessed by the therapy department for the above intervention.On 12/18/25 at 4:55 PM, a Nursing note documented . Resident had an unwitnessed fall in the common area. No s/s (sign/symptoms) of injury. Refusing assistance. He is upset and yelling. Does have a language barrier so not sure what is bothering him to cause him to yell. Resident continued to scream.A review of the Physician orders and Medication Administration Record (MAR) for December 2025 documented, . Alprazolam Tablet 0.25 mg (milligrams), Give 1 tablet by mouth three times a day for anxiety. Start date 12/18/25 and discontinued 12/21/25.On 12/19/25 at 9:41 AM, a Nursing note documented . IDT MET CP (care plan) reviewed resident has increased agitation possible sundowning, medication added for anxiety.A review of the Physician orders and December 2025 MAR documented - Ativan tablet 0.5 mg, twice a day for agitation and anxiety- Start date 12/21/25. Seroquel 25 mg, one time dose administered on 12/21/25 at 1:06 PM, for agitation and Seroquel 25 mg at bed time for agitation and anxiety (Start dated 12/21/25.)On 12/23/25 at 1:19 AM, a Nursing note documented . Writer heard yelling and entered room to find pt (patient) on the floor with head resting on bed. On 12/23/25 at 9:29 AM, a Nursing note documented . IDT met, CP reviewed. Concave mattress added for defining mattress perimeters.On 12/24/25 at 12:56 AM, a Nursing note documented . Pt (patient) observed on floor, CNA (Certified Nurse Assistant) had just put pt in the bed. Pt was found kneeling on the left side of the bed with [NAME] <sic> and truck <sic> laying across the bed. Pt was aggressive and verbally yelling, would not allow writer to assessed for vital signs.On 12/24/25 at 9:34 AM, a Nursing note documented . IDT met and reviewed case, resident to have medication review. Resident has behaviors and has frequent agitation.A review of the Physician orders and December 2025 MAR documented- Alprazolam 0.25 mg tablet by mouth every 24 hours as needed for agitation, anxiety. Give at HS (hour of sleep). This medication was documented as administered on 12/25/25 at 9 PM.On 12/26/25 at 2:17 AM, a Nursing note documented . Family contacted to assist in redirecting pt as he was yelling out in the common area. Family request that staff put the pt in the bed, pt was placed in bed. Writer had just left the room after checking on pt, pt was in bed; bed was in the lowest position possible. CNA check on pt 10 minutes post writer checking and pt was observed on the floor. no injuries observed. Pt returned to wheelchair and placed in common area. Education render to family regarding keeping pt safe from falls. IDT met, CP reviewed.A review of the incident and accident report dated 12/26/25, confirmed the resident was observed on the floor at 2:06 AM.On 12/26/25 at 8:28 AM, a Nursing note documented . IDT reviewed care plan regarding fall w/o (without) injury, root cause resident has poor safety awareness, and impulsive. Care plan reviewed and updated sfety <sic> education provided to family, when resident is restless shouldn't be in room alone placed in areas of high vision such as common area and activities.A review of the Physician orders and December 2025 MAR documented- Seroquel 50 mg by mouth in the evening for agitation and anxiety and Xanax tablet 0.5 mg by mouth at bedtime for agitation and anxiety. Start date for both medication was 12/26/25.On 12/27/25 at 8 AM, a telehealth Encounter note documented . Witnessed fall no new injury or pain.On 12/27/25 at 8:43 AM, a Nursing note documented . Writer was notified by incoming nurse that resident was on the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	floor. Writer entered residents room and observed the resident on his bottom by the right side of his bed. Resident stated that he was trying to reach for his phone charger when he fell out of his bed.On 12/29/25 at 1:29 AM, a Nursing note documented . Writer heard yelling. Upon entering pt room, Pt was observed on floor laying on the left side of the bed on his left side with his head toward the foot of the bed.On 12/29/25 at 10:01 AM, a Nursing note documented . IDT met and discussed will request family to bring in a longer cellphone cord to ensure item can be within reach.A review of the Physician orders and December 2025 MAR documented- Ativan 0.5 mg, one tablet by mouth twice a day for anxiety. Start date 12/29/25.A Nursing note dated 1/3/26 at 11:11 AM, documented in part . Resident's daughter (daughter's name) is requesting that resident is sent out to Hospital related to his fall history within the last two weeks. Writer assessed resident and notified on call (on call clinician name). Residents Daughter (daughter name) called a non emergent number and EMS (Emergency Medical Services) techs arrived. Resident was sent out to the hospital via families. request via transportation service that arrived. This note was documented by Nurse Manager (NM) D.A review of an Ambulance run sheet dated 1/3/26, call received at 11:06 AM, documented in part . Primary Impression- Altered Mental Status. Secondary Impression - Urinary Tract Infection (UTI). Duration 2 weeks. 11:19 BP 144/110. And it was delayed on scene due to conflict between family and facility staff. The mental status is noted as confused, with a deviation from baseline that is difficult to ascertain based on family and facility history. a blood pressure of 144/110 mmHg; and a Glasgow Coma Scale (GSC) score of 11, with specific scores of 4 for eye-opening response, 5 for motor response, and 2 for verbal response. The pulse is irregularly irregular but strong. The ECG (Electrocardiogram), conducted with a 3-lead, shows atrial fibrillation. The patient was transported emergently without the use of lights or sirens to (hospital name), as per family choice.A hospital Emergency Medicine consultation dated 1/3/26 at 12:57 PM, documented in part .1/3/26 at 12:57 PM an Emergency Medicine consultation documented in part, . CHIEF COMPLAINT: FALL, SMELLING URINE. He presents to the Emergency Center today complaining of foul-smelling urine. Patient arrives from a facility. Per history from nursing/triage, daughter concerned that patient is not being taken care of properly at his facility. Patient has dementia, oriented to person only at baseline. Daughter is at bedside providing history. Reports the patient is at his baseline mental status though reports that he was recently moved to a rehab facility from his assisted living due to frequent falls. She reports that he continues to have frequent falls. Came to the ER (Emergency room) for fall recently. Has bruising on his face from this. Unsure of last fall. She also notes foul-smelling urine. And the patient reporting that he is having some pain with urination. Daughter has not noticed any new injuries. She states the patient at times states that he has a sore throat. Ill-appearing. Chronically ill-appearing, no acute distress. Moves all extremities symmetrically. Bilateral upper extremity tremor noted. Sensation intact throughout. Cognition is impaired. Hips Bilateral with Pelvis 3-4 Views- Impression 1. Mildly displaced avulsion-type fracture involving the left ischial tuberosity at the common hamstring origin. [AGE] year-old male with a history of dementia presenting with generalized weakness, multiple falls, foul-smelling urine. On exam, chronically ill-appearing though no acute distress. No focal neurologic deficits. At baseline neurologic/mental status. No acute signs of trauma noted. Benign abdominal exam. Patient with increased agitation here in the ER. Has underlying dementia. Daughter okay with Zyprexa. This resulted in improvement of agitation X-ray of the pelvis ordered as well given history of multiple falls which shows a left ischial avulsion fracture. I discussed with the orthopedic surgery, consistent with a hamstring injury, no operative/orthopedic needs. Labs were otherwise mostly reassuring, mildly elevated creatinine. complete blood count with mild anemia, no leukocytosis. COVID, influenza my (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	interpretation are negative. However patient is weak, multiple falls, with urinary tract infection. Plan for admission to medicine, IV antibiotics, likely needs PT. I discussed the case with admitting hospitalist who accepts admission.Plan remains admission to medicine, now with Neurosurgery consult, neuro checks. Disposition: Admission.Final Impression: Urinary tract infection, generalized weakness, left ischium fracture.An attempt to interview the Licensed Practical Nurse (LPN) C was made on 2/2/26 at 2:12 PM and unsuccessful. LPN C did not return the surveyors phone call. This was the nurse assigned to R201 on 1/3/26 when they were transferred to the hospital.On 2/2/26 at 2:17 PM, NM D was interviewed and asked about R201's transfer to the hospital on 1/3/26. NM D stated the resident was due to be discharged from the facility and the daughter did not want to take R201 home because they did not have the means to take care of the resident. NM D stated R201's daughter asked that the resident be transferred to the hospital. NM D stated they called the on call doctor who stated they had no reason to transfer the resident out. NM D stated they informed the doctor that the family wanted the resident transferred to the hospital and the Physician agreed to the transfer. NM D stated they called the facility's Director of Nursing (DON) to update them on the situation and Emergency Medical Services was already at the facility to pick up the resident. NM D stated R201's daughter called EMS to transfer the resident out.On 2/2/26 at 2:38 PM, the DON was interviewed and asked about the interventions of the therapy screening for assist bars and reacher to not have been completed and the intervention of the family to have been educated regarding fall safety when it was the facility staff that reached out to the family because of the resident yelling in the community room in the middle of the night. The DON stated the family was educated because the family told the staff to put the resident in bed. The note was reviewed which noted the documentation of the phone call at 2:17 AM, in which the facility staff documented . Family contacted to assist in redirecting pt (patient) as he was yelling out in the common area. When asked why the resident was kept in the common area during the night considering the resident had a documented fall that occurred in the community room as well, the DON repeated that this is why the family was educated. The DON was asked how the facility provided adequate night time supervision for the resident considering most of their falls were documented to be at night and the DON stated the resident was placed in the community room for increased supervision. The DON stated they would look into the concerns and follow back up. At 4:05 PM, the DON returned and stated they were unable to provide documentation of the resident to have been assessed for the assist bars and reacher.Review of a facility policy titled Fall Management last revised 7/8/25, documented in part . The facility will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls. Each resident in attaining/maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and/or functional programs as appropriate to minimize the risk for falls. The Director of Nursing/designee is responsible for coordination of an interdisciplinary approach to managing the process for prediction, risk evaluation, treatment, evaluation, and monitoring of resident falls.No further explanation or documentation was provided by the end of the survey.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2709710.Based on interviews and record reviews the facility failed to ensure non-pharmacological interventions were consistently utilized before the administration of pharmacological interventions, failed to ensure appropriate indication for psychotropic medications, failed to revise and individualized the behavioral health care plan, and ensure behavioral health service monitoring for one (R201) of one resident reviewed for falls. Findings include:A review of the hospital referral provided to the facility upon R201's admission documented the following in part, . Hospital Problem List - Open fracture of nasal one, initial encounter. Nasal septum fracture. Nasal laceration. Fracture of fingers, left. Fall. Syncope and collapse.A review of the medical record revealed R201 admitted to the facility on [DATE], with diagnosis that included: dementia, alzheimer's disease, falls, major depressive disorder, glaucoma, and fracture of the nasal bones. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 03, that indicated severely impaired cognition and required staff assistance for all Activities of Daily Living (ADLs). A review of a care plan titled . impaired communication r/t (related to) has some confusion and his primary language is Arabic as evidenced by Confusion, Language barrier.A review of a Nurse Practitioner (NP) note dated 12/18/25 at 8 AM, documented in part . CHIEF COMPLAINT - Agitation. seen today for increasing agitation. Nursing staff and several residents report that patient was up all night and morning screaming and yelling. Staff unable to distract or redirect patient behavior. Patient currently sitting in common area looking at television. No yelling at this time. He is currently on Mirtazapine and sertraline, Xanax 0.25 mg (milligram) has been added for anxiety. Interventions: Monitor Non-pharmacological Intervention.There was no documentation from the Nursing staff regarding the Agitation observed throughout the night and morning. Further review of the record revealed no documentation of non-pharmacological interventions attempted by the staff. A review of the Physician orders and Medication Administration Record (MAR) for December 2025 documented, . Alprazolam Tablet 0.25 mg, Give 1 tablet by mouth three times a day for anxiety. Start date 12/18/25 and discontinued 12/21/25.A review of a NP note dated 12/21/25 at 8 AM, documented in part . CHIEF COMPLAINT. behaviors and agitation. seen today for increasing agitation. He is seen at bedside. He is yelling and screaming, waving his arms. He appears very upset and mad. He is pointing fingers at staff. He is not redirectable. He is not combative with staff. Per nurse he has been screaming non stop all day and night and his family had to come at night to help put him <sic> bed. He is disruptive to other residents due to constant screaming. Xanax 0.25 mg bid was recently added. He is also taking Remeron 7.5 mg qhs (every hour of sleep) and Zoloft 50 mg qd (every day). Alzheimer's disease, unspecified: patient has confusion which is chronic and ongoing. Medication not indicated for dementia given age and severity of disease. continue to monitor for changes in cognition. Restlessness and agitation; Patient has been acutely restless, agitation, screaming for several days. Xanax was initially ordered. Today, will d/c (discontinue) Xanax 0.25mg, will order Ativan 0.5mg bid (twice a day), will order one time dose of Seroquel 25mg NOW, will order Seroquel 25mg at night. Will continue Zoloft, Remeron 7.5mg qhs.A review of the Physician orders and the December 2025 MAR documented the following:Ativan tablet 0.5 mg, one tablet twice a day for agitation and anxiety. Start date 12/21/25 and discontinued 12/25/25.Seroquel 25 mg one time dose administered on 12/21/25 at 1:06 PM, for agitation.Seroquel 25 mg at bed time for agitation and anxiety at bedtime (9 PM). Start date 12/21/25.Review of the record revealed no prior diagnosis of psychosis or anxiety.A review of a Nursing note dated 12/24/25 at 9:34 AM, documented . IDT (interdisciplinary team) met and reviewed case, resident to have (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication review. Resident has behaviors and has frequent agitation.A Behavior Note dated 12/25/25 at 9:54 PM, documented in part . Resident sat in common area and yelled at the top of his lungs in his language stating he wants to go, call the police and other verbal statements. Unable to redirect. ADON (assisted director of nursing) attempted, Writer continually attempted. Pt (patient) give <sic> PRN (as needed) Xanax 0.25mg with no effect.A review of the Physician orders and December 2025 MAR documented the following:Alprazolam 0.25 mg tablet by mouth every 24 hours as needed for agitation and anxiety. Give at HS (hour of sleep). This medication was documented as administered on 12/25/25 at 9 PM.A NP note dated 12/26/25 at 8 AM, documented in part . He is friendly and cooperative. No yelling or agitation at this time. Nursing and other patient continue to report patients <sic> is agitated and screams all night. Increase Xanax 0.5mg HS. Adjust Seroquel 50mg 1800 (6 PM) in attempt to better manage his sundowning behavior.A review of the Physician orders and December 2025 MAR documented the following:Seroquel 50 mg by mouth in the evening for agitation and anxiety. Start date 12/26/25.Xanax tablet 0.5 mg by mouth at bedtime for agitation and anxiety. Start date 12/26/25.Review of a telehealth Encounter note dated 12/28/25 at 8 AM, documented in part . pt. is extremely aggited <sic> and anxious, He use to have Ativan 0.5 BID but they changed the order to Q HS, one time dose of Ativan 0.5mg ordered, rounding provider to follow up.A Nursing note dated 12/28/25 at 5:56 PM, documented in part . Patient was exhibiting s/s (signs/symptoms) of anxiety and agation <sic> this evening. Wrtier <sic> got one time order for Ativan 0.5mg.Further review of the record revealed no documentation of a description of the observed s/s of anxiety and agitation and no documentation of non-pharmacological interventions attempted prior to the administration of the one time dose of Ativan.A review of the Physician orders and December 2025 MAR documented the following:Ativan 0.5 mg, one tablet by mouth twice a day for anxiety. Start date 12/29/25.Further review of the medical record revealed no documentation on why the Ativan was added twice a day on 12/29/25.A review of a Statement of Capacity documented the resident was . incapable and unable to make his/her informed medical decisions. dated 12/19/25. This put into effect R201's Durable Power Of Attorney (DPOA) that documented R201's daughter to be able to make medical decisions on the behalf of their father.Review of the Physician orders noted the following order implemented on 12/12/25 Psych services to eval (evaluate) and treat as indicated.A review of the care plans revealed the following:A care plan titled . has an actual behavior problem R/T (related to) has a dx (diagnosis) of dementia episodes of yelling/screaming out. Initiated: 12/22/25. The interventions were as noted . Administer medication as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Anticipate and meet resident's needs. Approach in a calm manner. Caregivers to provided opportunity for positive interaction, attention, Stop and talk with him/her as passing by. Document behaviors, and resident response to interventions. If reasonable, discuss resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Observe behavior episodes and attempt to determine underlying cause, Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Praise any indication of resident's progress/improvement in behavior. Provide a program of activities that is of interest and accommodates residents status. Provide additional caregivers to provide care as needed. Psych consult as needed.The care plan was implemented 10 days after admission.A care plan titled . potential for fluctuations in mood. initiated 12/22/25, documented the following intervention . Arrange specialized mental health services as indicated on the level II assessment.A review of the medical record revealed no consents obtained for the multiple psychotropic (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications or a consent for behavioral health services.The facility did not implement interventions to monitor for adverse reactions or side effects of the antipsychotic and antianxiety medications administered.On 2/2/26 at 1:29 PM, the Director of Social Services (DSS) B was interviewed and asked what R201's targeted behaviors were and how the facility tracked/monitored the behaviors. DSS B stated they believed R201 had behaviors of falling and trying to get up out of bed. DSS B stated they had just started their employment at the facility around R201's stay at the facility. When asked if they had any involvement in the behavioral plan of care and the implementation of non-pharmacological interventions, DSS B stated they did not. When asked about the multiple prescribed psychotropic medications and if they consulted with behavioral health services for R201, DSS B reviewed R201's record in their laptop and stated they did not. DSS B stated usually the interdisciplinary team would meet and discuss the behavioral and medication needs of the resident to discuss an interdisciplinary approach. DSS B stated after meeting they should have approached R201's daughter for consent of the psychotropic medications. When asked, DSS B replied in part . We should have discussed them as a team before putting him on it (psychotropic medications).On 2/2/25 at 2:38 PM, the Director of Nursing (DON) was interviewed and asked what R201's targeted behaviors were and the DON replied that R201 . yelled out and was resistive to care. The DON was asked about the multiple psychotropics prescribed by multiple different NP, doctors and/or clinicians and stated the resident was being followed by the medical team. The DON was asked if the resident was referred to behavioral health services and stated they did not believe so. When asked about the multiple psychotropic administrations without documentation of prior attempts of non-pharmacological interventions, the lack of oversight of the use of multiple psychotropic medications with the same classification, and the lack of behavioral monitoring/management, the DON acknowledged the concern.No further explanation or documentation was provided by the end of the survey.A review of a facility policy titled Behavior Management revised 4/20/2023, documented in part . The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/functional programs as appropriate and safety interventions to minimize behaviors. The IDT works with the resident and/or family/legal representative to determine an appropriate plan of care to identify the cause of the behavior and/or treat the behavioral symptoms.A review of a facility policy titled Psychoactive Medication Management revised 1/28/26, documented in part . The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/functional programs as appropriate and safety interventions to minimize the use of psychotropic medications in managing behaviors when non-pharmacological interventions have failed. Non-pharmacological interventions are the first choice in management of behavioral symptoms. those with new psychoactive medications orders or an increase in the dose of the medication, will have a psychotropic medication informed consent completed. Before initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase.