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	03/18/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2634630.Based on interview and record reviews the facility failed to report an allegation of mistreatment to the State Agency (SA) and failed to follow the facility policy for one (R716) of three residents reviewed for abuse. Findings include:A review of a complaint submitted to the SA documented in part . the staff is being aggressive and rough with (R716 name) resulting in her feeling injured afterwards.A review of the medical record revealed R716 was admitted to the facility on [DATE] with diagnoses that included: acute respiratory failure, macular degeneration and conductive hearing loss. A Minimum Data Set (MDS) assessment dated [DATE], that documented a Brief Interview for Mental Status (BIMS) score of 8 (moderately impaired cognition). R716 required staff assistance for all Activities of Daily Living (ADLs).A review of a grievance dated 9/24/25, completed by Social Services Technician (SST) D documented in part . Son (son name) informed me that he would like his mother moved to another facility, as (R716 name) feels she is being treated rough by staff. Hair pulled, legs pulled, current cut on her leg as well. (R716 name) is fearful of retaliation from staff. Action To Be Taken - Resident moved to 1st floor.On 3/17/26 at 1:41 PM, the Administrator who is also the facility's abuse coordinator was interviewed and the 9/24/25 grievance was reviewed. When asked, the Administrator stated they were unaware of the rough care and mistreatment allegation. When asked if it should have been reported, the Administrator stated it should have.On 3/17/26 at 1:49 PM, SST D was interviewed and asked about the grievance. SST D remembered having the conversation with R716's son and stated the resident was transferred to another facility. When asked who they reported the allegation to, SST D stated they reported the concern to the Administrator.A review of the facility policy titled Abuse Prohibition Policy dated 10/14/22, documented in part . Each guest/resident shall be free from abuse. mistreatment. The staff will report any allegations or suspicions of mistreatment. and injuries of unknown source to the Administrator and DON (director of nursing) immediately. The Administrator or designee will notify. State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 citation pertains to intakes: 2795651 & 2796703. Based on interview and record reviews the facility failed to ensure acceptable standards of Nursing care and services was provided for one (R704) of two residents reviewed for a change in condition. Findings include: A complaint submitted to the State Agency (SA) noted the following in part: On 2/22/26 the family member of (R704) received a call that R704's oxygen had dropped under 90%. The family member raced to the nursing home to find R704 hallucinating with the oxygen tank empty and nasal cannula on the floor. They informed R704's nurse of the 02 (oxygen) tank being empty and the oxygen tubing to be observed on the floor and the nurse instructed the family member to put the oxygen tubing back into R704's nose. The family member asked the nurse if the resident was tested for a UTI (Urinary Tract Infection) and the nurse replied, We don't do those on Sunday. The family member noted the nurse did not come in to assess the resident, so the family member called 911. EMS (Emergency Medical Services) arrived and assessed the resident's 02 at 86% and transferred the resident to the hospital.A review of the medical record revealed R704 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: chronic diastolic congestive heart failure, chronic kidney disease, type 2 diabetes mellitus with diabetic neuropathy and urinary tract infection. The family member (daughter) was noted as the resident's POA (Power of Attorney) for care/financial and documented responsible party.A review of the medical record revealed the following:On 2/22/26 at 1:14 PM, a Nursing note documented in part . pt (patient) noted to be hallucinating. NP (Nurse Practitioner) notified and assessed pt at bedside. Vita signs obtained BP (blood pressure) 124/57, HR (heart rate) 66, 02 (oxygen saturation) 90%. Pt placed on 2L (liters) 02 via nasal cannula.The Physician orders revealed the following:2/22/26 UACS (urinalysis, culture & sensitivity).2/22/26 Oxygen 2L per nasal cannula. Titrate 02 to keep oxygen saturation above 93%. Every shift for 02 Sat </= 90%.On 2/22/26 at 1:17 PM, a Nursing change in condition note that documented in part, . Altered mental status. pt stated she is seeing a lady standing in the corner and tickles her feet and legs occasionally. Primary Care Provider responded. Pt needs a UA (Urinalysis) and oxygen therapy.The Oxygen levels were reviewed and none were identified and documented under 90% for R704. There was no additional respiratory assessments completed by the nursing staff identified in the medical record.On 2/22/26 at 4:30 PM, a Nursing note documented in part . Pts daughter called 911 at approximately 1625 (4:25 PM) due to concern for pts hallucinations. Pt repeatedly removed oxygen from face despite frequent redirection. Oxygen was placed back on residents' face; however, resident continued to take it off. Education and reassurance provided without sustained compliance. Per family request pt was sent to the hospital for further evaluation. Pt transferred via EMS in stable condition. Supervisor notified.On 2/22/26 at 6:45 PM, a Nursing note documented in part . Daughter called facility requesting prior documentation be changed to reflect that pt was unstable upon departure. At the time of EMS departure pt was observed sitting upright, drinking a beverage, and was not wearing oxygen. Request to alter documentation was declined. Supervisor notified of daughter's request and situation.The above nursing notes were documented by Licensed Practical Nurse (LPN) E.A review of the EMS report dated 2/22/26 at 4:41 PM, documented in part . Upon arrival pt was sitting in bed. confused. Pt was accompanied by daughter at bedside. This morning staff notified daughter that pt had low SP02 (Oxygen Saturation) levels. Daughter requested a urinary analysis to be done but staff stated that it cannot be done on the weekend. Staff on scene stated EMS was unable to speak to pt's nurse due to her not being present so HX (history) was primarily obtained from daughter. Pt did present lethargic and confused appearing to be having visual hallucinations. Pt SPO2 was 86 on room air, we administered 02 15 lpm (liters per minute). Eyes were restricted but reactive to light. Pt remained on 15 lpm via NRB (non-rebreather) which kept SPO2 stable. Pt was continually reassessed and monitored throughout transport.On 3/18/26 at 11:25 AM, LPN E was interviewed and asked about the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident of R704's family to have called EMS to transfer the resident to the hospital on 2/22/26 and LPN E replied . I'm not sure. LPN E was asked to review their notes from that day. LPN E then stated they recalled that the resident was hallucinating. LPN E was asked if they remembered what level R704's SPO2 had reached that required the resident to need supplemental oxygen as no level under 90% was documented in the medical record and LPN E stated . I don't remember. LPN E was asked about the daughter arriving to the facility to find the oxygen tank empty and 02 tubing on the floor and not connected to the resident's nasals and informing them of the findings and LPN E stated they did not remember, but knew the resident took the oxygen off. LPN E was asked why R704's daughter had to call 911 and LPN E replied in part . Her daughter called 911 herself because her mother was having hallucinations and it was not normal for her to act that way. LPN E was asked how they ensured that the resident's oxygen was being continuously provided as ordered to keep the resident stable and safe and LPN E replied they did rounding. LPN E was asked how often they rounded to ensure R704's oxygen was in place and LPN E replied . I don't remember how often the rounding was. LPN E was asked if they were present when EMS was in the building and LPN E confirmed they were. When LPN E asked why they did not provide the EMS staff with the needed medical information and documentation for R704, LPN E replied . I don't remember. LPN E was asked if they informed the family that UA's are not completed on the weekend, LPN E replied . I'm not sure if I made that remark, but yes UA's are completed on Sundays, but would have to wait until Monday for pickup and have to be re-done anyway. LPN E was asked if they considered an SPO2 level of 86% on room air to be stable as noted in their documentation and LPN E replied No. LPN E was then asked why they documented in the medical record that the resident was stable, up drinking a beverage and not wearing oxygen, when EMS obtained a 86% pulse ox on RA and LPN E stated . I don't know.On 3/18/26 at 12:16 PM, an interview was conducted with the Administrator and Director of Nursing (DON), the medical record, EMS report and LPN E interview was reviewed and both were asked if the facility staff are able to obtain Urinalysis on the weekends and both stated they were. The DON was asked the normal protocol for a resident who is hallucinating and requiring supplemental oxygen and allegedly removing the needed oxygen. The DON replied they would expect increased rounding, keeping the resident in at eye sight and if they can't keep them safe and stable to send them out (to the hospital). They were asked about the LPN E to not provide the EMS with the necessary documentation and information for transfer and the DON stated the nurse should have provided the medication list, face sheet, and advance directives. When asked about LPN E documentation to note the resident to be stable, with findings identified by EMS of the resident to have an SPO2 of 86% on RA, and with no oxygen applied as ordered by the physician. The DON stated they understood the concern and would start education with the nurse.A review of a job description for Charge Nurse (provided by the Administrator who stated all the nurses were classified as Charge Nurses) was reviewed and revealed the following, . The Charge Nurse plans, coordinates, provides and manages nursing care, nursing services and health education to nursing home residents. The position requires patience, compassion, and a desire to care for the residents in a gentle and empathetic manner. Provides treatments per the physician order. Accurately transcribes and coordinates. Transfer of residents to hospital. Performs nursing assessments regarding the health status of residents. Accurately reports and documents the resident's symptoms, responses and status. initiate any required nursing interventions. Responds to resident and family concerns promptly; ensures that each concern is documented and a resolution is initiated. Coordinates. transfers of residents.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake 2702800, 2746398, 2800213, 2651998, 2646662, 2634630, 2795651, 2796703, 2649843, 2785783, and 2749201. Based on observation, interview, and record review, the facility failed to ensure adequate provision of activities of daily living care including incontinence care for four Residents (R703, R708, R709, and R715) of ten residents reviewed for activities of daily living and incontinence care. Findings include: Review of several complaints received by the State Agency revealed allegations of residents waiting extended times for their call lights to be answered, resulting in residents laying in urine-soaked briefs, hygiene concerns, and staffing and care concerns. Three of the complaints were reviewed as follows: Received on 3/04/26. Alleged R703 was regularly left soaked in urine for 12 hours at a time, several times during their three week stay. Alleged resident was only given three showers in a week and had poor hygiene care including grooming. Received on 2/13/26: Alleged the facility was short staffed, causing R708 and R709 to be left soiled and (allegedly) developed UTI's (urinary tract infections). Received on 10/23/25: Alleged staff did not respond appropriately to R715's call lights, provide timely incontinence care, respond to grievances adequately, and alleged low staffing. On 3/16/26 at 11:26 a.m., Licensed Practice Nurse (LPN) O was asked about resident care and any residents being left wet. LPN O acknowledged they were finding residents left soaked (with urine) sometimes when they arrived on their morning shift. LPN O reported they tried to find the aides to talk with them but they typically had left already. LPN O explained they knew residents were waiting sometimes at least a couple hours to be changed, by finding a dark ring of urine in their briefs when they changed them. LPN O explained the third floor where they worked held up to 57 residents, and said they needed five aides during the day on their unit to provide adequate resident care. LPN O said when there were only three aides, the residents care suffered, which resulted in residents who waited 1-2 hours for care including incontinence care on the day shift, because the residents wanted to get up at the same time. During further interview regarding what they did about their concerns, LPN O said they provided education (when care was lacking) to the aides and reported their concerns to management. LPN O said the concern was the quality of the workers and not enough workers at times. LPN O was asked if they believed residents were getting urinary tract infections from laying in wet briefs for extended periods, and responded it was possible. LPN O shared some residents' showers were getting missed when staffing was low, and they sometimes gave residents showers themselves when this occurred. LPN O believed if the building had a shower team, this would resolve the problem and said they had recommended this to management but there was no shower aide as of yet on the unit. R709 On 3/17/26 at 12:28 p.m., R709 was observed in their room, dressed and seated in a wheelchair. On 3/17/26 at 12:30 p.m., R709 was asked about their care, and said during the day they waited at least an hour often for assistance, and sometimes at night they waited more than one hour for their brief to be changed. R709 said this caused them to feel uncomfortable, upset, and frustrated. R709 asked Surveyor to speak with their family member about their concerns. R709 said they, their family, and other residents had shared their concerns about long call wait times with the administrator however the situation remained. R709 was able to tell time accurately from the clock in her room and was alert and oriented to themselves, their surroundings, situation, schedule, and place. Review of R709's Minimum Data Set (MDS) assessment, dated 2/09/26, revealed R709 was admitted to the facility on [DATE] with diagnoses including heart disease, morbid obesity, and anxiety. The assessment showed R709 was dependent for toileting and transfers and was frequently incontinent of urine and occasionally incontinent of bowels. The standardized cognitive assessment showed R709 was cognitively intact. Review of R709's Care Plan revealed they transferred with two-person assistance to and from the toilet, per their preference. On 3/17/26 at 2:56 p.m., Certified Nurse Aide (CNA) P was asked about resident care and any residents (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being left wet. CNA P indicated they worked all the shifts, and were concerned about short staffing, which was happening on all shifts, but at night the most. CNA P said there were many residents who needed two-person assistance on R709's floor, at least five residents on R709's assignment wing, who required longer time for extended care needs. CNA P said when there were three aides to 50 residents, that gave each of the aides on the floor 16 to 17 residents a piece to provide care especially morning care to get them up including showers. CNA P explained they struggled because there were many residents in the facility who were heavy wetters (urinated at a higher volume) and needed two-person assistance to be changed or transfers, including R709. CNA P said they struggled to take a break because when they did there were not enough staff to cover the unit, and residents could fall without enough supervision. CNA P said everybody was waiting one to two hours at night for their call lights to be answered, and described they were finding residents wet when they started their morning shift, which concerned them for the residents, some of whom complained. CNA P stated sometimes they found R709 soaked when they arrived on shift, which upset them and caused them to have behaviors. CNA P said they believed R709 when they said they waited one to two hours to be changed as they were fully oriented and could tell time. On 3/18/26 at 9:29 a.m., R709's Family Member (FM) S, was asked in a phone interview about R709's care at the facility. FM S explained on weekends, nights, and holidays the staff called off frequently, and said R709 waited 1-2 hours for their brief to be changed when they were incontinent. FM S said they knew this because their mother called them when this occurred. FM S said this last occurred two weekends ago and had happened over the last few months. FM S said in February (2026) there was a weekend when were only two aides on R709's floor on the night shift. FM S spoke to the aides, who told them they had 26 patients each to care for, which they said was too many residents. FM S said another resident across the hall, R708, also waited extended periods and was found soaked by their family member. FM S reported they also came in and completed their mother's showers when the facility was short staffed, which was hard on them because they worked many hours. FM S said R709 still received their showers but only because they assisted when the aides did not have time, and their family member required them at least twice a week due to incontinence and per their preference. Review of the (Name of) unit assignment sheet on 2/27/26 showed two aides worked from 11 p.m. to 7:00 a.m. They were assigned to rooms 314 - 328, room [ROOM NUMBER], and rooms 331-2 to 339-2. There was no aide (name) next to rooms 301 - 313, 329 - 1, 329-2 and 331-1. This documentation was obtained from the midnight schedule binder at the 3rd floor nurse's station. It was noted R708 and R709 were in rooms 301 - 313. R708 On 3/18/26 at 10:03 a.m., R708's Family Member, FM Q, was asked during a phone interview about their care at the facility. FM Q said they were very excited for their family member to come to the facility but then disappointed their family member would lay there 45 minutes to 1 hour in a wet brief frequently, especially during the night shift. FM Q reported they decided not to bring their family member back to the facility after a second hospitalization for another urinary tract infection, when the problem (lacking incontinence care) kept recurring. FM Q said they filed several grievances, and the management staff were aware, however the poor incontinence care continued to recur, which was upsetting to them and R708. FM Q alleged the management said they did not have enough staffing and they were sorry. FM Q explained there were only two staff on (working) at night occasionally (verses three required) on R708's unit. Review of R708's grievance form, received via email from the facility, dated 10/12/25, completed by FM Q , showed concerns regarding R708 being left wet all night and found soaked and crying by the morning aide, which FM Q found inexcusable. The employee (name withheld) was removed from working with the resident and education was provided on answering call lights and completely care timely in the response. Review of R708's MDS assessment, dated 1/08/26, revealed R708 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease (a progressive neurological disorder), anxiety, and depression. The assessment showed R708 was dependent for toileting and toileting transfers and was frequently incontinent of bowel and bladder. The standardized cognitive assessment showed they had moderate (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive impairment. R703 Review of an email received by Surveyor from FM T on 3/17/26 at 11:04 a.m., revealed a picture of a dark yellow large urine-soaked open brief, with the title, First Incident. Attached was a grievance form, which was dated 1/11/26, signed by Family Member T . The grievance form showed, in part, .Today is the second time in four days my mom has not had her brief changed at night. When changed by the day shift today at 10 a.m., her brief was excessively saturated from top to bottom. I was told there would be check and changes every two hours as required by the state. Additionally, I was assured she would be checked frequently due to her UTI and it is not happening.When did the .incident occur. Fri (Friday) 1/9, and Sun (Sunday) 1/11 (2026). I personally changed her at 11:30 a.m. 1/11, 10:00 a.m (discovered).How can we address your issues? Ensure that check and changes occur every two hours and that she is changed if at all soiled. There should be a tool that logs all changes with time noted. The lack of changes is a serious health concern.Is this an ongoing problem? Yes. Since she became a resident. It was signed as received by a supervisor. Review of a second email by FM T received on 3/17/26 at 11:05 a.m. was titled, Second Incident, with a picture of a large dark yellow heavily urine-soaked brief. This grievance showed, in part, .When did the problem occur? Today, Wed (Wednesday), Jan (January) 14 (2026). 10 a.m. (discovered) when changed.Make it a requirement that my mother is changed at a minimum every 4 hours as well as disciplinary action for night shift aide. Is this an ongoing problem? Yes. Ever since admission. Have you contacted us in the past about this issue? Yes. DON (Director of Nursing) and Administrator. Signed by FM T and dated 1/14/26. Review of a third email by FM T received on 3/17/26 at 11:05 a.m. was titled, Third Incident, with a picture of a large yellow urine-soaked brief read, in part, .Again, my mom did not have her diaper changed last night. It is overly saturated and the bed pad was wet. They used a pull up (incontinence brief) after her shower last night verses her normal brief and it was still on her. Additionally, she was in the exact same position I left her in last night - wedge and pillows. When did the problem occur? Night shift. 1/15/26. 9:00 a.m. (discovered).How can we address your issues? Write a dr order to be changed every 4 hours and ensure it happens, disciplinary action, document each change so aides know when the last one took place. Is this an ongoing problem? Yes. Since admission. Have you contacted us in the past about this? Yes. DON.Admin. Review of a fourth email by FM T , received on 3/17/26 at 11:07 a.m, was titled, Fourth Incident, which stated, I did not file an incident each time, only on the worst instances. She (R703) was only there 3 weeks and typically was only changed 3 times per day unless I forced (pushed) them (staff) to add a 4th in the afternoon. Totally substandard care.There were two grievances included in this email, which the first read as follows: Review of the first grievance stated, My mother did not get her shower last night when she is scheduled to get one on night shift on Sat (Saturday) and Wed (Wednesday). This is the second Sat (Saturday) in a row it did not happen. Nurse (unnamed) advised it was never assigned to a CNA. When did the problem.occur? Night shift 1/17/26.How can we address your issues? Ensure showers are happening as scheduled as this is critical to proper hygiene.Is this an ongoing problem? Yes. 2 Saturdays in a row. Have you contacted us before about this issue? Yes. This was dated 1/18/2026 and signed by FM T . Review of a second grievance form attached in the same email by FM T showed, My mom was changed about 5 p.m. I assumed she was still dry when they put her to bed so I called about 10:30 p.m. and asked for her to be changed. I got the feeling it would not happen based on the call so I stopped by on my way home about 12:15 a.m She (R703) had not been ch (anged). (paper cut off). This was signed and dated 1/18/26. Review of R703's MDS assessment, dated 1/12/26, revealed R703 was admitted to the facility on [DATE], with diagnoses including atrial fibrillation (heart rhythm disorder) and a urinary tract infection (UTI). The assessment showed R703 was dependent for toileting and transfers, and frequently incontinent of bladder, and occasionally incontinent of bowel. The standardized cognitive assessment showed R703 had severe cognitive impairment. Review of R703's resident census report revealed they were a resident at the facility from 1/07/26 through 1/29/26. Review of R703's shower log record, received via email from the facility, on 3/18/26 at 6:03 p.m., for January 2026, revealed four entries for (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers in January 2026, dated 1/10, 1/17, 1/21 and 1/24 (2026). Two of the four entries were initialed by staff. The other two entries showed one was designated, NA and the second was designated, RR. The facility Director of Nursing (DON) was asked for clarification of what these meant. No clarification was received by the end of the survey. It appeared NA may have been indicative of Not Attempted and RR may be indicative of Refused so there was no way to verify R703 received more than two showers during a 22-day period. It was noted R703's shower days were on Monday and Wednesday per the log, with Wednesday, 1/14/26, showing as a blank box (no indication of why or if missed). The DON confirmed the only shower records were in the Electronic Medical Record (EMR) and there was no other shower documentation. R715Review of R715's grievance, received from the facility via email, dated 12/04/25, revealed, .Extremely negative demeanors and attitudes. Length of call light on as long as 1 1/2 hours, staff having private phone calls while I'm being cared for. Never return after turning off call light. When did problem occur? 2-3 times a week, Saturday 11/30, Sunday 12/01 (2025). Time (checked) a.m. and p.m. It was noted they told the Administrator. The facility response was noted as, Weekend supervisor has been hired. Customer service training for all staff. Action to be taken: Continued education and promotion of customer service skills. The response was dated 12/09/25. Review of R715's grievance, received via email from facility, dated 10/02/25, revealed, .6 am call light put on and out at 6:30 a (a.m.), was ignored.Action to be taken: Staff educated on call light response time. The response was dated 10/07/25. Review of R715's grievance, received via email from facility, dated 10/04/25, revealed, .Call light (on) 11 a.m.- 1:15 p (p.m.), told will be back to assist but never came back. Common occurrence. dated 10/04/25. Response was, Facility to do follow-up. Inservice with all staff on response times and helping w/ (with) call lights. The response was dated 10/13/26. Review of R715's grievance, dated 10/18/25 thru 10/19/25, revealed, No services (assistance) after 12-hour period for personal changing. Call light used three times. It was shut off but no aide provided (care). When did this occur? Friday into Saturday. Who else knows about the problem? General staff and voice messages to management and to State Offices. How can we address your issues? (Alleged) as of todays date no bath service.Action to be taken: Educated staff on proper notification if there are barriers to care. The response was dated 10/31/25. Review of R715's census showed they were a resident at the facility from 9/30/24 to 1/21/26. Review of R715's MDS assessment, dated 1/06/26, revealed R715 was admitted to the facility on [DATE] with diagnoses including kidney disease, muscle atrophy and weakness, anxiety, and depression. R715 was dependent for toileting hygiene and transfers and was frequently incontinent of bladder and occasionally incontinent of bowel. They were cognitively intact per the standardized cognitive assessment. Review of R715's grievances, including other grievances during their stay, showed they expressed ongoing concerns related to extended call light wait times related to not being changed timely. The grievances showed management had been made aware however ongoing care concerns remained.On 3/18/26 at approximately 5:00 p.m., the R703's, R708's, R709's, and R715's concerns and grievances related to adequate provision of activities of daily living and incontinence care respective to showers and call lights not being answered timely, and residents being left in wet briefs for extended periods were reviewed with the DON. The DON reported they understood the concerns related to lacking incontinence care for these residents. R703's shower log was reviewed with the DON, who wished to follow up with possible explanation for the interpretation of the initials (meaning) on two of the four logged shower entries, when Surveyor shared it appeared R703 only received two showers during their three week stay (22 days), as only two of the entries were clearly initialed by staff. On 3/18/26 at approximately 5:30 p.m., the same residents and concerns respective to adequate provision of activities of daily living including incontinence care and R703's missed showers were reviewed with the Nursing Home Administrator (NHA). The NHA acknowledged there was a grievance process in place, and they had responded to the grievances, and had no additional comment. The NHA noted R103's family member had reported they sent several grievances however they had not received or seen them all. The NHA (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was made aware of the concerns regarding the DON wishing to review R703's shower log further, in the event either had an additional comment. On 3/18/26 at 6:06 p.m., R703's shower log was received, with no explanation provided regarding logged identifiers for two of the four dates. Review of the policy, Routine Resident Care, revised 3/12/25, revealed, Residents receive the necessary assistance to maintain good grooming and personal/ oral hygiene. Steps are taken to ensure that a resident's capacity for self-performance of these activities does not dimmish unless circumstances of the resident's clinical condition demonstrate the decline is unavoidable. Care is taken to ensure resident safety at all times. Guidelines.8. Incontinence care is provided timely according to each resident's needs. 9. Resident's call lights are answered timely and resident's requests are addressed if permitted.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2785783 and 2634630. Based on observation, interview and record review the facility failed to provide timely assistance with feeding for two residents who required feeding assistance (R702 and R718) out of four residents reviewed for food concerns. Findings include:Complaints were filed with the State Agency (SA) that alleged concerns with staffing and that residents that required assistance with eating were not receiving timely assistance with meals due to staffing issues and not always receiving food as ordered. On 3/17/26 at approximately 12:30 PM, an attempt to observe lunch service for residents eating in their rooms on the second-floor north hall (Willow Lane) was conducted. At 12:30 PM, no trays had been delivered to that area. A resident was observed sitting on a couch eating what appeared to be food not provided by the facility. Sitting near the resident was R718. R718 kept eyeing the other residents' food. An attempt to interview R718 was made. R718 appeared confused and not able to verbally answer the question as to whether they were hungry. Continued observations were made. At approximately 12:50 PM food trays started to be passed to residents who resided on [NAME] Lane. At approximately 1:02 PM, a tray was delivered to the resident near R718. R718 did not receive any food at that time. R718 continued to watch the other resident eat from the tray provided by the facility. A tray was delivered to R702's room at approximately 1:03 PM and placed on the entry way counter. A staff member entered R702's room to assist at approximately 1:14 PM. At approximately 1:23 PM, R718 still had not received their lunch. R718 continued to eye the other resident eating their lunch and grabbed the residents' half eaten cup of chocolate ice cream from their tray and started to eat the other residents food. Following the observation noted above, the Surveyor reported to Nurse L that R718 had taken the resident's ice cream off their lunch tray. Nurse L was then asked why R718 had not received their lunch yet as it was almost 1:30 PM. Nurse L reported that R718 needed assistance with eating and there were not enough staff to help the feeders at the same time. Nurse L was asked as to how many residents needed assistance when eating and they reported they thought at least four or five residents on [NAME] Lane. R702 On 3/17/26 at approximately 10:20 AM, R702 was observed lying in bed. Both the right and left hand were contracted. There was food items located near the window and several cups of water that were out of reach of the resident. The resident was alert and able to answer questions asked. When asked about care at the facility, R702 reported that staff were generally nice but they did not believe there was enough staff to take care of their needs. They noted that they needed assistance with most everything, including eating. R702 reported that at times they wait hours to get changed. With respect to eating, R702 stated they always need assistance with eating as they can't use their hands. They stated sometimes they don't get mechanically soft food, and they are not able to eat. The resident noted that their concerns have been reported to the facility. A review of R702's clinical record noted the resident was initially admitted to the facility on [DATE] with diagnoses that included: Parkinsons Disease, Depression and muscle weakness. A review of R702's Minimum Data Set (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 13/15 (cognitively intact cognition). Continued review of the resident's MDS noted the resident was dependent on others to bring utensils and liquid to their mouth once the meal is placed in from of them. A review of R702's diet order noted the resident was to receive a mechanically soft diet. R718 A review of R718's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease, dementia, unspecified severity with psychotic disturbance and metabolic encephalopathy. A review of the MDS noted the resident had a BIMS score of 1/15 (severely cognitively impaired). An order dated 3/6/26 noted R718 was ok to have x1 mechanical soft snack daily for pleasure with SUPERVISION. On 3/18/26 at approximately 5:20 PM, an interview was conducted with the Administrator. The Administrator was asked about concerns related to staffing and feeding assistance. The Administrator reported that the facility is well staffed but noted at times they are not clear as to the timing of services provided.

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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 - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2634630 Based on observation, interview and record review the facility failed to ensure wound care was administered both timely and correctly for one (R719) of five residents reviewed for wound care. Findings include:On 3/18/26 at approximately 11:30 AM, Certified Nursing Assistant (CNA) J reported that R719 had some concerns to discuss pertaining to their wound care. R719 was then observed sitting in their wheelchair. A family member was also in the room. R719 reported that on 3/17/26 at approximately 11:30 PM, they asked Nurse M if they were going to change their wound dressing as they had not had it changed since 7 AM that morning and to their understanding they had an order to change their wound two times per day (morning and bedtime). R719 reported that after they asked to have their wound dressing changed, Nurse M told them that they were not going to provide wound care because they were too busy as they had been assigned 29 residents. R719 stated on 3/18/26 at approximately 3:30 AM, Nurse M came back to their room and provided wound care. However, they were certain Nurse M did not follow the physician's order as they felt they did not have the right supplies and when they asked Nurse M what they were applying, Nurse M told them not to worry about it. The wound was observed. The dressing applied by Nurse M did not cover the wound and approximately one third of the wound was exposed. Yellow like soaked padding was attached to the wound. R719 noted that they never had yellow padding before. R719 was very worried as to the status of their wound. They stated the facility could not apply a wound vac as ordered upon admission and understood that it could not be done by the facility however, in lieu of wound vac, following the treatment ordered correctly and timely helped to ease the fear that the wound would go septic. At the time of the observation, the resident's family member noted they had been with the resident almost daily and had never seen the wound care treatment completed so poorly. The family member was leaving the room to talk with administrative staff at the time of interview. A review of R719's clinical record revealed the resident was initial admitted to the facility on [DATE] with diagnoses that included: Unspecified open wound, left lower leg, cellulitis of left lower limb, acute kidney failure and type II diabetes. A review of the residents Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (intact cognition). Continued review of R719's clinical record documented the following: 3/11/26: Nurses Summary: Resident admitted from hospital.resident diagnosis left leg debridement. 3/12/26: Nurses Note: Resident stated she was told that she would be placed on a wound vac.no current orders noted.only order for bedtime treatment. 3/12/26: Order: clean wound with wound cleaner wrap wound with wet kerlix apply ABD (abdominal-highly absorbent wound dressings) wrap with co-flex at bed time. 3/13/26: Skin Issues: Skin issues.left shin.Surgical wound.length cm (centimeters) 36 width 10.73 Depth (cm).Area (cm2) 273.25 .Granulation: 80%. Slough: 20 % .Serosanguineous mixture of serous and sanguineous fluid . 3/13/26: Skin/Wound Progress Note: The writer and unit manager attempted to apply wound vac therapy to (R719) LLE (left lower extremity) but was unsuccessful. 3/16/26: Skin/Wound Progress Note: .called (hospital).and asked for plastic surgery resident.(R719) surgical wound on her LLE & wound vac not being able to be applied properly. 3/17/26: Order: LLE: Clean with wound cleanser, pat dry, apply opticell AG, ABD pads, wrap with kerlix, then secure with Ace bandage.every day shift AND as needed. 3/17/26: Order: LLE: Clean with wound cleanser, pat dry, apply opticell AG, ABD pads, wrap with kerlix, then secure with Ace bandage.at bedtime AND as needed. 3/18/26: Medication Administration: Wound tx (treatment) completed d/t dressing soiled. On 3/18/26 at approximately 3:27 PM, an interview was conducted with Wound Nurse (WN) F. WN F was asked about R719. WN F reported that they were familiar with R719 and noted that they were aware of the residents wound. They noted that the wound was significant and initially the resident had an order for a wound vac, however the facility had difficulty applying it. When asked about the yellow pads that were applied by Nurse M, WN ?F noted that yellow pads were most likely Xerofoam and not (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the resident's order. When asked if Nurse M should have left the wound exposed, they noted that it should have been covered per their order(s). On 3/18/26 at approximately 3:36 PM, a phone interview was conducted with Nurse M. Nurse M was queried as to the treatment that was given to R719 on 3/18/26. Nurse M recalled that the resident requested the treatment and that they were very busy that evening. They noted that they eventually were able to provide the treatment. When asked about the yellow pads that had been applied, Nurse M noted that they can't recall exactly what they applied but just followed the order. On 3/18/26 at approximately 3:11 PM, an interview was conducted with the Administrator. The Administrator reported that they were aware of R719's concerns and noted that treatment should be provided as ordered. The facility policy titled, Physician's Order (8/20/25) was reviewed and read, in part: .Purpose: Physicians orders are obtained to provide a clear direction in the care of the resident.Treatment rendered to a resident must be in accordance with the specific standing, written, verbal.order of a physician or other licensed health professional.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake(s): 2795651, 2796703, 2786658, 2725790, 2634630 Based on observation, interview and record review the facility failed to ensure a resident at risk for pressure ulcers was timely assessed and timely treated for pressure ulcers for one (R706) of five residents reviewed for pressure ulcer/wound care resulting in R706 obtaining a facility acquired stage 4 pressure ulcer that required hospitalization and surgery and pain. Findings include:A complaint was filed with the State Agency (SA) that alleged the resident went to (name redacted) hospital on 2/17/26 with a right buttock wound and it could not be determined when the woundstarted. Hospital records from 2/17/26 to 2/24/26 were reviewed and revealed, in part, the following: .chief complaint: WOUND CHECK.Patient is alert and oriented x3.She presented via EMS (emergency medical services) from (facility) for evaluation of sacral wound.Patient reports an open wound on her right buttock which has worsened over the past week. Patient is unable to recall when her buttock wound started.she reports she is mistreated at her facility which caused her buttock wound.she has a wound on the base of her right buttock with an opening the size of a quarter. The skin surrounding the wound is black, with foul smelling drainage.Imaging via CT (computed tomography).demonstrate no acute fractures, however shows a phlegmonous lesion (soft tissue infection) of the inferior right gluteal region with concerning for abscess.plan.Patient boarded for OR (operating room) debridement of sacral wound.pt underwent incision and drainage of right gluteal abscess, debridement of necrotic skin on 2/17/26. Focal examination of wounds:.Location: Right ischium - stage 4 pressure injury, status post debridement on 2/17/26.Measurements: 8X5.5X4.5 cim (centimeters).Wound cx (laboratory test) grew S aureus (staphylococcus infection) and ESBL (extended -spectrum beta-lactamases/e-coli). On 3/17/26 at approximately 10:40 AM, R706 was observed lying in bed. The resident was alert and able to answer most questions asked. R706 was asked about their most recent hospitalization pertaining to their wound. The resident reported that they still have the wound on their bottom and it hurts sometimes. They stated that it was currently being treated. R706 was not able to provide when the wound started and noted that they did not receive any treatment before they went to the hospital. R706 reported that they just wanted to leave the facility and go home as they worried about some staff members as some of them were rude and they do not always get help. A review of R706's clinical record revealed the resident was initially admitted to the facility on [DATE]. R706's last admission to the facility was on 2/24/26 with diagnoses that included: pressure ulcer of right buttock, stage 4, type II diabetes and schizophrenia. A review of the residents Minimum Data Set (MDS) with a target date of 2/26/26 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 13/15 (cognitively intact). Braden (assessment used to assess residents' risk of developing a pressure ulcer) scores obtained upon admission and continuously throughout their stay at the facility noted the resident was at mild risk for developing pressure ulcers. Continued review of R706's clinical record revealed the following: 11/18/25: Hospital Discharge Record: .Sacral shallow partial thickness wound.no drainage.Left gluteal wounds.one shallow partial thickness wound that measures .5 cm (length) x 2.5 cm (width).Interventions: Buttocks and sacrum: cleanse wound space with bath wipe.apply a dime thick layer of Triad ointment BID (twice a day) and PRN (as needed).continue [NAME] isotour bed (pressure mattress). 11/18/25: Nursing Comprehensive Evaluations (SKIN): No risk.Does the resident have any skin condition: YES.Description: .left trochanter (hip).open area.left buttocks areas not open. 11/19/25: Skin/Wound Progress Note: The writer assessed (R706) skin and noted no active wounds. Authored by Wound Nurse (WN) F. 11/23/25: MDS Section M- Skin Conditions: .Resident has a pressure ulcer/injury over bony prominence.NO.Is this resident at risk of developing pressure ulcers: YES. A review of the residents' MAR/TAR (medication/treatment administration record) and skin treatment orders for the months November 2025, December 2025 and January 2026 showed no indication that any treatments, including prophylactic treatments, pertaining to wounds/pressure (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ulcers were provided. 2/12/26: Skin Issues: .Location: Right Gluteal Fold.New wound. Wound acquired in house.length 5.11 width (cm): 4.25 Depth (cm).sanguineous fluid, typically pale, read, and watery. Authored by WN F. 2/14/26: Order/TAR (Treatment Administration Record): Right Gluteal fold: Clean with wound cleanser, pat dry, apply triad paste, cover with dry gauze or foam dressing every day shift or foam dressing every day shift for promoting wound healing.*It should be noted that treatment for the wound started two days after it was found. 2/17/26: Wound Care: .Visit type: Wound Care.patient being seen today for wound evaluation and assessment.Positives: Wounds.Notes: Pressure unstageable Right Gluteal Fold. Measures 4x4 x 5.9 cm. 100% slough. Small hole present draining purulent drainage. Malodor present.Patient will be sent to the hospital. (Authored by Wound Nurse Practitioner (WNP) G. 2/25/26: History and Physical: .R706 was a resident in facility and re-hospitalized for a R (right) buttock necrotic would with abscess and underwent I & D (incision and drainage) on 2/17/26.I am seeing her today for readmission.mild generalized pain.complete abx (antibiotics) with minocycline. Local wound care and pressure offloading. On 3/18/26 at approximately 11:00 AM, an interview and record review were conducted with WN F. WN F reported they had been employed by the facility for over a year. WN F was asked about the facility protocol pertaining to wounds/pressure ulcers and their involvement with all residents. WN F reported that all newly admitted residents are assessed for skin concerns upon admission. As a Wound Nurse they also will do an initial evaluation. Thereafter, care plans and treatments are put into place to either prevent or start treating the wound. WN F also noted that following the initial assessments, nurse staff should, at a minimum, do weekly skin checks and report any concerns to them. They also noted that CNAs (certified nursing assistants) should also report skin issues to the nurses. The interview continued with WN F and R706's clinical record was reviewed. During the review it appeared that R706 had received only four noted skin checks from in-house nurses since their initial admission on [DATE]. WN F confirmed that skin checks should have been performed weekly. WN F was asked why R706's initial skin assessment/hospital records (11/18/25) that noted on discharge to the facility continue to apply a dime thick layer of Triad ointment BID (twice a day) and PRN (as needed). WN F noted that no treatments were put into place as they observed the resident upon initial admission and did not believe they had any open areas. When asked when and how the wound to the right buttock was discovered, WN F reported that a nurse informed them about the wound on or about 2/12/26. When asked who the nurse was, WN F was able to provide a first name only. WN F was asked about their observation of the wound on 2/12/26 and they reported they believed the wound was unstageable with slough and eschar and confirmed the wound was acquired in house. WN F was asked if they believed 2/12/26 was the day R706 acquired the wound. They reported that based on their observation the wound was not acquired on 2/12/26 and as nursing staff did not do weekly skin checks they were unable to determine the actual date. WN ?F was asked about R706's hospitalization pertaining to the wound and they reported WNP G recommended the resident be sent to the hospital as they believed the wound was infected and needed further treatment. On 3/18/26 at approximately 3:24 PM, a phone interview was conducted with WNP ?G. WNP G was queried as to when they were informed of R706's wound and decision to send the resident to the hospital. WNP ?G reported that the first time they saw R706 was on 2/17/26. They reported that the wound had a strong odor with drainage and believed the wound needed to be debrided. When asked if they were aware of R706's risk for wounds and when the wound started, WNP G reported they believed the resident was a new admit and again saw the resident for the first time on 2/17/26. An attempt to contact the Nurse(s) (hereinafter Nurse H and Nurse I) based on the first name provided by WN F was made on 3/18/26 at approximately 3:34 and 3:36 PM. Voice messages were left for both nurses. Nurse H returned the call at approximately 3:43 PM. When asked if they had reported R706 skin concerns to WN F they indicated they did not. Nurse I did not return the call prior to the end of the survey. On 3/18/26 at approximately 3:50 PM, an interview was conducted with the Director of Nursing (DON). The DON was queried about R706's facility acquired pressure wound. The DON reported that they were not employed by the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	facility at that time, however based on the resident's history and the facility's protocol R706 should have received timely and at least weekly skin assessments/checks. The facility policy titled Skin Management (1/28/26) was reviewed and revealed the following: .Policy- It is the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries.those at risk for compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing .A skin check evaluation is completed for each resident by the licensed nurse weekly. The licensed nurse will document findings on the skin check evaluation. The CNA will report any new skin impairment to the licensed nurse that is identified during daily care.A Resident at Risk meeting will be conducted at least monthly by the Interdisciplinary Team (IDT). During this meeting, the IDT will evaluate skin changes, review treatment modalities, interventions and will make recommendations as needed. Care Plan and resident Kardex will be updated.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This complaint pertains to Intake #2702800. Based on observation, interview and record review the facility failed to ensure a resident with a history of Urinary Tract Infections (UTI) received timely urine samples causing a delay in treatment and extended pain for one (R702) out of three residents reviewed for UTI's. Findings include: A complaint was filed with the State Agency (SA) that alleged it took over four days to obtain a urine specimen to determine treatment for a UTI. The complainant further alleged that staff blamed the delay on the resident not drinking enough water and noted that R702 could only drink water with staff assistance, and they felt there was either a lack of staff or staff did not respond timely to residents call light. On 3/17/26 at approximately 10:20 AM, R702 was observed lying in bed. Both the right and left hand were contracted. There was food items located near the window and several cups of water that were out of reach of the resident. The resident was alert and able to answer questions asked. When asked about care at the facility, R702 reported that staff were generally nice, but they did not believe there was enough staff to take care of their needs. They noted that they needed assistance with most everything, including eating and drinking. R702 reported that at times they wait hours to get changed and have frequent UTIs. A review of R702's clinical record noted the resident was initially admitted to the facility on [DATE] with diagnoses that included: Parkinsons Disease, Depression and muscle weakness. A review of R702's Minimum Data Set (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 13/15 (cognitively intact cognition). Continued review of the residents MDS noted the resident was dependent on others to bring utensils and liquid to their mouth once the meal is placed in from of them. Continued review of R702's clinical record revealed, the following: 2/1/26: Nurses Notes: Late entry for 1/31/26.Resident c/o (complains of) mild pain when urinating. Logged in MD (medical doctor) book to visit resident. 2/2/26: Progress Notes: .As per patient and staff patient has dysuria (pain and/or burning during urination).mild suprapubic (lower abdomen) tenderness.NP (nurse practitioner) encouraged hydration. Ordered UACS (uranalysis culture). 2/2/26: Nurses Notes: UA sample needed attempted twice. Will endorse to the incoming nurse. 2/3/26; Nurses Notes: Straight catheterization for UA sample, collection done along with CNA (certified nursing assistance). But backflow is so limited to a few milliliters. Residents brief is soaked. 2/4/26: Nurses Notes: Writer unsuccessful at attempting to obtain UA sample.endorsed to oncoming shift. 2/4/26: Progress Notes: .seen today for an acute visit regarding UTI symptoms.patient states that she has burning with urination. On examination, patient has suprapubic/flank tenderness. Urine same collected via a straight catheter. Urine is yellow, cloudy with heavy sediment and odorous.patient encouraged to increase oral fluid intake. 2/4/26: Nurses Notes: Urine sample collected on this day by NP and was put in fridge but was mistakenly discarded will endorse to the next shift. 2/5/26: Nurses Notes: Attempted straight catheterization x3 and unsuccessful. 2/7/26: Nurse Practitioner Note: UA + (positive).awaiting culture for appropriate antibiotic treatment. 2/11/26: Progress Notes: .follow up visit regarding urine culture results.patient reports she still has suprapubic tenderness and burning.Nitrofurantoin (Macrobid -antibiotic) 100 mg Q6h (every 6 hours) x 5 days.Encouraged patient to increase oral fluid intake.patient anxious and tearful concerning UTI. On 3/18/26 at approximately 5:16 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked as to the facility protocol on obtaining urine samples for a resident with signs of a UTI. The DON reported that generally a urine sample is obtained and the culture takes five days to determine the correct antibiotics to administer to a resident. The DON was asked as to the long delay in obtaining a urine sample for R702. The DON noted that they were not employed at the time but noted it appeared as if there were some difficulties obtaining the urine via a straight catheter and could not explain why it was discarded and had to be started over again. The DON was not able to provide an answer as to the (continued on next page)

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	03/18/2026

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extended delay. The facility policy titled, Urine Culture (11/24/25) was reviewed and noted the following: .Description: Helps

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: 2795651 & 2796703.Based on interview and record reviews the facility failed to ensure oxygen therapy and maintenance was administered as ordered by the Clinician for one (R704) of one resident reviewed for respiratory care. Findings include:A complaint submitted to the State Agency (SA) noted the following in part: On 2/22/26 the family member of (R704) received a call that R704's oxygen had dropped under 90%. The family member raced to the nursing home to find R704 hallucinating with the oxygen tank empty and nasal cannula on the floor. They informed R704's nurse of the 02 (oxygen) tank being empty and the oxygen tubing to be observed on the floor and the nurse instructed the family member to put the oxygen tubing back into R704's nose. The family member noted the nurse did not come in to assess the resident, so the family member called 911. EMS (Emergency Medical Services) arrived and assessed the resident 02 at 86% and transferred the resident to the hospital.A review of the medical record revealed R704 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: chronic diastolic congestive heart failure, chronic kidney disease, type 2 diabetes mellitus with diabetic neuropathy and urinary tract infection. The family member (daughter) was noted as the resident's POA (Power of Attorney) for care/financial and documented responsible party.Further review of the medical record revealed the following:On 2/22/26 at 1:14 PM, a Nursing note documented in part . pt (patient) noted to be hallucinating. NP (Nurse Practitioner) notified and assessed pt at bedside. Vita signs obtained BP (blood pressure) 124/57, HR (heart rate) 66, 02 (oxygen saturation) 90%. Pt placed on 2L (liters) 02 via nasal cannula.A Physician orders revealed the following:2/22/26 Oxygen 2L per nasal cannula. Titrate 02 to keep oxygen saturation above 93%. Every shift for 02 Sat </= 90%.On 2/22/26 at 1:17 PM, a Nursing change in condition note that documented in part, . Altered mental status. pt stated she is seeing a lady standing in the corner and tickles her feet and legs occasionally. Primary Care Provider responded. Pt needs a UA (Urinalysis) and oxygen therapy.The Oxygen levels were reviewed and none were identified and documented under 90% for R704. There was no additional respiratory assessments identified in the medical record.On 2/22/26 at 4:30 PM, a Nursing noted documented in part . Pts daughter called 911 at approximately 1625 (4:25 PM) due to concern for pts hallucinations. Pt repeatedly removed oxygen from face despite frequent redirection. Oxygen was placed back on residents' face; however, resident continued to take it off. Education and reassurance provided without sustained compliance. Per family request pt was sent to the hospital for further evaluation. Pt transferred via EMS in stable condition. Supervisor notified.On 2/22/26 at 6:45 PM, a Nursing note documented in part . Daughter called facility requesting prior documentation be changed to reflect that pt was unstable upon departure. At the time of EMS departure pt was observed sitting upright, drinking a beverage, and was not wearing oxygen. Request to alter documentation was declined.The above nursing notes were documented by Licensed Practical Nurse (LPN) E.A review of the EMS report dated 2/22/26 at 4:41 PM, documented in part . Upon arrival pt was sitting in bed. confused. Pt was accompanied by daughter at bedside. This morning staff notified daughter that pt had low SP02 (Oxygen Saturation) levels. Daughter requested a urinary analysis to be done but staff stated that it cannot be done on the weekend. Staff on scene stated EMS was unable to speak to pt's nurse due to her not being present so HX (history) was primarily obtained from daughter. Pt did present lethargic and confused appearing to be having visual hallucinations. Pt SPO2 was 86 on room air, we administered 02 15 lpm (liters per minute). Eyes were restricted but reactive to light. Pt remained on 15 lpm via NRB (non-rebreather) which kept SPO2 stable. Pt was continually reassessed and monitored throughout transport.On 3/18/26 at 11:25 AM, LPN E was interviewed and asked about the incident of R704's family to have called EMS to transfer the resident to the hospital on 2/22/26 and LPN E replied . I'm not sure. LPN E was asked to review their notes from that day. LPN E then stated they recalled that the resident was hallucinating. LPN E was asked if they remembered what level (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R704's SPO2 had reached that required the resident to need supplemental oxygen as no level under 90% was documented in the medical record and LPN E stated . I don't remember. LPN E was asked about the daughter arriving to the facility to find the oxygen tank empty and 02 tubing on the floor and not connected to the resident's nasals and informing them of the findings and LPN E stated they did not remember, but knew the resident took the oxygen off. LPN E was asked why R704's daughter had to call 911and LPN E replied in part . Her daughter called 911 herself because her mother was having hallucinations and it was not normal for her to act that way. LPN E was asked how they ensured that the resident's oxygen was being continuously provided as ordered to keep the resident stable and safe and LPN E replied they did rounding. LPN E was asked how often they rounded to ensure R704's oxygen was in place and LPN E replied . I don't remember how often the rounding was. LPN E was asked if they considered an SPO2 level of 86% on room air to be stable as noted in their documentation and LPN E replied No. LPN E was then asked why they documented in the medical record that the resident was stable, up drinking a beverage and not wearing oxygen, when EMS obtained an 86% SPO2 on room air and LPN E stated . I don't know.A review of a facility policy titled Respiratory assessment, respiratory therapy revised 2/24/25, documented in part . Documentation associated with respiratory assessment includes: date and time of the assessment. pulse oximetry readings. respiratory rate and rhythm. depth of respirations. presence or absence of respiratory distress. breath sound changes from previous assessment. abnormal findings. prescribed interventions. response to those interventions.A review of a facility policy titled Use of Oxygen revised 2/28/25, documented in part . To promote the safety in administering oxygen. tubing should be kept off the floor.