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	06/10/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2987034.Based on interview and record review, the facility failed to ensure interdisciplinary care plan reviews were completed with the resident and/or legal representative, included the required interdisciplinary team (IDT) members, and were done in accordance with each Minimum Data Set (MDS) assessment for two (R43 and R120) of three residents reviewed for care plan review, resulting in the lack of opportunity for the resident and/or legal representative to participate in discussion of treatment options and decisions which pertain to all aspects of their plan of care. Findings include:Review of a complaint to the State Agency on 4/17/26 included concerns with care planning conferences and alleged there was no nursing involvement and only the physical therapist, dietician and the social worker came to the meeting. R43Review of the clinical record revealed R43 was initially admitted into the facility on [DATE], discharged on 4/12/26 and readmitted on [DATE] with diagnoses that included: end stage renal disease, metabolic encephalopathy, sepsis, bacteremia, methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere, hypo-osmolality and hyponatremia, rhabdomyolysis, and acute metabolic acidosis.According to the quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/19/26, R43 had intact cognition, received a therapeutic diet, and received dialysis.Review of the care planning documentation revealed the most recent documented care conference was done on 2/4/26. There was no documentation that a care planning review was completed with R43 and the IDT for the quarterly MDS assessment with an ARD of 3/19/26. R120Review of the clinical record revealed R120 was initially admitted into the facility on 9/25/25 and readmitted on [DATE] with diagnoses that included: vascular dementia moderate with anxiety, anxiety disorder, post-traumatic stress disorder unspecified, suicidal ideations, major depressive disorder recurrent moderate, hypertensive heart disease without heart failure, other speech disturbances, metabolic encephalopathy, type 2 diabetes mellitus with diabetic neuropathy, obesity, Alzheimer's disease, personal history of traumatic brain injury, and obstructive sleep apnea.According to the quarterly MDS assessment with an ARD of 3/23/26, R120 had severe cognitive impairment. The profile information in the electronic health record (EHR) documented R120 was their own responsible party, and their spouse was their emergency contact.Review of the care planning documentation revealed the most recent documented Interdisciplinary Care Conference evaluation was done on 12/31/25. The one prior to this was on 10/1/25. There was no documentation that any other Interdisciplinary Care Conference evaluation were completed with R120 and/or their family or the IDT for the significant change MDS with an ARD of 2/5/26, or the quarterly MDS assessment with an ARD of 3/23/26.Review of an additional document scanned into the EHR revealed a Care Plan Report that further documented By signing below, you are verifiing <sic> that you participated in this resident's plan of care. This document contained signatures from activity staff, social work, dietician, and the Physician. There was none for nursing staff and the section for Resident/Family was blank.On 6/9/25 at 10:25 AM, an interview was conducted with the MDS Coordinator (Nurse ?E'). When asked to explain the facility's process of scheduled and conducting (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235733	A. Building B. Wing	06/10/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care planning reviews with residents and their family/representatives, Nurse ?E' reported the MDS staff were responsible for scheduling and sending the care conference invitations and the first care conference is done within 72 hours of admission and a second one is done within 7-10 days and documented in the EHR. Nurse ?E' further reported then a care conference would be held every three months for the long term residents. When asked who was involved in those reviews, they reported it would be the dietician, social work, and nursing. When asked about nursing assistants that work directly with the residents and/or the physician/providers, Nurse ?E' reported they looked at that documentation as well and referenced the care plan report document for signatures. On 6/9/26 at 2:55 PM, another interview was conducted with Nurse ?E'. When asked to review R43's MDS assessments and care conference documentation of any reviews that were done and identify who the involved staff were, Nurse ?E' confirmed there was no care conference completed since 2/4/26. When asked about the quarterly MDS assessment with an ARD of 3/19/26 and why there wasn't another care conference completed with this review, Nurse ?E' reported their corporate staff told them to complete the quarterly with an ARD of 3/19/26 in order to not affect their quality measures. When asked if another MDS assessment was completed such as the quarterly or significant change, why wouldn't the resident and/or family and IDT be included in that review, Nurse ?E' reported they should have been and was unable to explain why that didn't happen.On 6/9/26 at 3:16 PM, an interview was conducted with the Director of Nursing (DON) who reported they had been in their role for about 35 days. When asked about the facility's process for who participates in the care planning conference reviews with the residents and/or their family/representatives, the DON reported for the quarterly and annual MDS's the MDS nurses should attend and for the initial 72-hour conferences that should be the floor nurses and/or unit managers. The DON did report a recent turnover with nurse management staff. The DON was informed of the process reported by Nurse ?E' and concerns from residents that not all disciplines were in attendance and further acknowledged the breakdown in communication and need for further evaluation.According to the facility's policy titled, Care Planning Conference dated 2026: .On Admission, Quarterly, Annually, with a Significant Change and as needed, the interdisciplinary team will hold a care planning conference with the resident, family or representative in participation. The Care Conference will be used to identify the resident's potential or actual problems, needs, goals and discharge plans .In addition to the advance invitation, the resident will be notified and invited to attend the care conference on the care conference date .Each discipline is responsible for updating their care plans and Kardex. IDT members should have their information updated prior to the care conference to assist with timeliness .The recommended members of the interdisciplinary team care conference may include: Nursing Representative, Social Services, Activities, Dietary, Nurse Assistant, Resident, Family and/or responsible party, Therapy as needed, Other member of the IDT as needed .Documentation and notes will be taken on the Interdisciplinary Care Conference evaluation in (EHR) .Care Plan Signature page can be printed from (EHR) print options on the Care Plan. All attending parties will sign and then this page will be scanned into the residents EHR in the Document tab .A summary of the residents plan of care will be provided to the resident &/or resident representative.

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	06/10/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3030553 Based on observations, interviews, and record reviews the facility failed to develop, implement, and monitor an effective restorative nursing program for two (R26 & R27) of three residents identified as having the potential to maintain or improve their functional abilities. The facility did not consistently assess residents for restorative nursing needs, establish individualized restorative goals, or ensure restorative interventions were provided as planned. Findings include: R26 On 6/08/26 at 1:30 p.m., R26 was observed in their hospital bed in their room, laying on their back, wearing a gown. Their heels were positioned directly on the mattress. R26's family member, FM AA, was present in their room with them. There was a tall bariatric recline wheelchair in their room with a wheelchair cushion in newer condition. It was noted R26's left hand was curled into a fist. R26's left leg was extended and rotated, with minimal edema, more pronounced on the dorsum of their left foot. On 6/08/26 at 1:33 p.m., R26 was asked about their positioning with FM AA present, and how often they were up in their wheelchair. R26 said they loved their wheelchair however there was a miscommunication among staff. R26 explained they used to get up in their wheelchair to go to the activities room but stopped because staff were leaving them up all day in the wheelchair, until the evening, which was too long for them. R26 indicated they would get up in their wheelchair for therapy or for activities for a specified time period. R26 said they liked being in therapy to sit up on the edge of the bed and for movement as they were not getting exercise or range of motion anymore. R26 said they liked it when their left leg was stretched out especially and said they used to have a left-hand splint which they liked but it was gone. It was noted R26 was oriented to his name, situation, and place during the interview. On 6/08/26 at approximately 1:37 p.m., FM AA said they had spoken to the former Director of Nursing (DON) about getting R26 up in their wheelchair for shorter periods, as they could not be up in their wheelchair all day. FM AA reported they were R26's guardian. R26 and FM AA both said R26 was positioned on their back only recently, but did get turned when they were changed, and denied having any skin concerns. FM AA said they both wanted therapy to improve his core strength to sit up in the wheelchair again, feeding himself without spilling food often, for the hand splint, and range of motion. Review of the Electronic Medical Record (EMR) revealed FM AA was R26's guardian. Review of R26's Minimum Data Set (MDS) assessment, dated 5/14/26, revealed R26 scored 14 on the Brief Interview for Mental Status (BIMS) assessment, which showed they scored in the cognitively intact range. The assessment revealed R26 required supervision to contact guard (cueing) assistance for eating and was dependent for toileting and chair-to-bed transfers. On 6/09/26 at 11:25 a.m., R26 was observed in their hospital bed wearing a gown laying on his back. R26's left hand was curled shut. R26 attempted and could not move their hand. R26 named their former Occupational Therapist (OT) and said they did not know why the splint was taken away, and said, It served its purpose with opening their hand. FM AA who was present was able to open R26's left hand to nearly full range with gentle gradual range of motion. On 6/09/26 at 3:40 p.m., R26 was observed in their hospital bed lying on their back. FM AA said they were present all day and had not observed R26 offloaded or on their side partially, which R26 confirmed. R26 denied getting any range of motion for their hand or extremities. FM AA said they had to do range of motion on R26 when they could since staff were not providing any range of motion. FM AA said they were in the facility at least three to four days a week for long days. On 6/09/26 at approximately 3:50 p.m., Licensed Practical Nurse (LPN) C was asked if there was a restorative program. LPN C said there had been one in the past but not for a considerable time, at least a few months. On 6/09/26 at approximately 3:55 p.m., LPN A was asked if there was a restorative program for R26, as they were their nurse. LPN A' said there had not been a restorative program for some time, and there was an open job posting for the position when they last checked. Review of R26's tasks showed they had not (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	06/10/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been receiving any range of motion, mobility, or splint application under tasks. Review of R26's tasks showed a positioning task, which showed repositioning of R26 was marked as completed, but not observed. On 6/09/26 at approximately 4:30 p.m., the Director of Nursing (DON) was asked if there was a current restorative nursing program or range of motion program for R26 in place. The DON reported they were newer to their position and hired in April and acknowledged there was no restorative nursing program. The DON said at the end of May (2026) they began initiating a program and hired a restorative aide and they had been doing training with them and therapy had done many evaluations of residents. The DON explained they had been educating the CNA they hired and were planning to initiate the program shortly. The DON shared this aide was currently working on the floor still as an aide and the program had not gotten off the ground yet but would be soon. The DON acknowledged R26 had not been getting range of motion exercises and was not receiving therapy. The DON said they received a list from therapy on Friday of the residents who had been recommended for a restorative nursing program and were not receiving services and said they would provide the list. The DON stated they are definitely going to get it started, and it will help with mobility and range of motion to prevent contractures. On 6/09/26 at 4:57 p.m., the DON returned with a list of residents who were supposed to be receiving restorative therapy services. There were seven residents on the list, including R26. On 06/09/2026 at approximately 5:26 p.m., R26 was observed with the DON, with FM AA present. R26 was offloaded slightly off their right side with a pillow underneath their shoulder and upper trunk. R26 had soft heel protectors in place, which FM AA stated were provided after the State survey started this week. FM AA reclarified to the DON and then said R26 had a left-hand splint which was lost in the laundry and they had not seen it for a few weeks and wanted another splint for R26's hand to hold it open. R26 and FM AA discussed their preferences regarding sitting up in the wheelchair but only for shorter periods per their tolerance. FM AA showed the DON R26's leg splint and said it was not being applied. Review of R26's current orders showed no orders for a left hand or leg positioning device / brace. Review of R26's Care Plan revealed the following: (R26) has a functional ability deficit and requires assistance with self-care/mobility r/t (related to) impaired mobility, hemiplegia and hemiparesis (weakness and paralysis) affecting L (left) non dominant side, cervical disc degeneration at C6-C7, CVA (stroke), impaired mobility, low back pain. Dated initiated 2/08/25 Left knee brace 2 hours per day for skin integrity before and after placement .initiated 5/14/25. L LE (lower extremity) brace on for 4 hours/day. Date initiated 5/18/26, pt (R26) to wear L hand (WHO) splint during sleep (nighttime hours 1 p (p.m.) to 7 a (a.m.). please gently perform rom (range of motion) prior to post splint wear. report any changes to OT dept (department). No observation of skin was noted. Review of documentation requested via email during the survey provided by the facility showed R26 had a restorative program prescribed for range of motion which was not being implemented, and no restorative notes. Program was dated 12/2025. On 6/10/26 at 8:57 a.m., the Director of Rehabilitation (DOR), Occupational Therapist (OT) B, was asked about R26's splint and restorative program, as well the facility restorative referral process. OT B acknowledged R26's left hand splint order was current, and nighttime wear was recommended as of 12/04/26 including the splint and upper extremity range of motion. OT B said R26 was just seen by PT (Physical Therapy) from 3/30/26 thru 5/13/26 including for their left leg brace, and they were supposed to be wearing this as well per their understanding. OT B noted R26 had been resistant at times about participating in therapy and getting out of bed however had not been made aware R26 reported sitting up all day. OT B indicated nursing services would designate how long a resident would be scheduled to stay up in a wheelchair, despite improving sitting tolerance in a wheelchair and sitting balance being a potential therapy goal, per standards of practice, if deemed appropriate by an evaluating therapist familiar with R26. OT B said they did not write orders for sitting or schedule days. OT B said they had not been made aware R26's splint was gone and offered to search their room with R26's permission. OT B said they could rescreen them and order another splint. Surveyor shared R26's goals of sitting up edge of bed for strength, range of motion, and going to activities. OT B concurred they (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	06/10/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would address R26's sitting tolerance as appropriate pending screening/ reevaluation. On 06/10/26 at 9:12 a.m., OT B was asked about a restorative program and said they we are making recommendations what (floor) staff can do since there is no restorative program currently. OT B acknowledged residents were declining without the program as evidenced by screening residents more frequently and picking people up residents in therapy since no restorative program. Review of R26's most recent therapy discharges from occupational and physical therapy revealed they were referred to restoratives therapy service upon discharge on [DATE] and 5/13/26 respectively, with no documentation of such found by OT B, surveyor, or DON. On 6/10/26 at 9:32 a.m., OT B met with R26 with Surveyor present and told OT B their left-hand splint had been gone for three weeks. OT B found R26's leg splint in their closet but did not find their left-hand splint. R26 shared they would like to participate in therapy services again and have another left-hand splint to hold their left hand open. R26 prior showed they had no volitional use of their left hand. R26 was wearing the left heel protective foam boots and was lying on their back. R27 On 6/08/26 at 11:45 a.m., R27 was in their room in their bed, and reported they fell when their knees collapsed, so they were counting on getting range of motion to their legs to strengthen them, as they hoped to get back onto therapy July 1 (2026). R27 said their legs were weak too and they wanted to strengthen their arms as well and wished someone was coming to their room to work with them until they could get onto therapy services. R27 was oriented to themselves, time, situation, and place and their schedule. On 6/09/26 at 12:33 a.m., R27 was observed in the dining room, seated in a standard manual wheelchair, feeding themselves with their left hand. No contractures were observed. Review of the EMR showed R27's BIMS assessment revealed they were cognitively intact. On 6/09/26 at 5:15 p.m., the DON was made aware R27 was requesting range of motion for their legs and strengthening for their arms, as well as therapy. Review of R27's physical and occupational therapy notes showed they had been referred to services for range of motion and walking upon discharge (from PT and OT), with no restorative notes or documentation showing any visits, attempts, or programming was found in the EMR, or received from the facility upon request. Review of R27's tasks showed no interventions for range of motion, mobility, or exercises in the past 30 days, per therapy discharge recommendations. Review of R27's physician orders showed no orders for range of motion or walking. On 6/10/26 at approximately 9:17 a.m., OT B noted R27's therapy discharge summaries referred R27 to restorative services upon discharge and noted they had a restorative program in place. On 6/10/26 at 11:04 a.m., the Nursing Home Administrator (NHA) was asked if they had a comment regarding the lack of a current restorative program or evidence of range of motion being done with two residents reviewed, R26 and R27. The NHA said they had been made aware R26's splint was missing but found this unusual and said it had not been found. The NHA acknowledged they were trying to get the restorative program up and running and shared a restorative aide quit so they had to identify another aide. The NHA said the nursing aides could also do range of motion and be assigned. Surveyor shared this was also not found on the tasks. The NHA reportedly understood the concerns regarding residents not receiving restorative programming recommended by therapy or range of motion by nurse aides and planned to continue to support the development of the program. The NHA noted R26's BIMS was 14 and understood the concerns. Review of the policy, Restorative Nursing, revised 4/26/24, revealed, The facility strives to enable the residents to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being. The interdisciplinary team (IDT) works with the resident and family to identify measurable restorative goals and practical interventions that can be implemented and achieved with nursing support. A licensed nurse will help manage the restorative program with assistance of nursing assistants trained in restorative care .Components of the restorative program include, but are not limited to, the following: Referral from skilled therapy services .

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	06/10/2026

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 #2963192. Based on observation, interview and record review the facility failed to prevent a fall for one Resident (R121) and failed to assess and provide interventions to prevent choking for one Resident (R79) out of seven residents reviewed for falls/accidents, resulting in R121 sustaining a fracture to the right femur, pain and extended hospital stay. Findings include: R121 A complaint was filed with the State Agency (SA) that alleged R121 fell out of bed and broke their hip. A review of R121's clinical record revealed the resident was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included: fracture of right femur, chronic kidney disease and type II diabetes. A review of R121's Minimum Data Set (MDS) dated [DATE] noted the resident had a Brief Interview for Mental Status (BIMS) score of 12/15 (moderate cognitive impairment). Continued review of R121's clinical record revealed the following: 3/30/26: Nursing Comprehensive: ADL (Activities of Daily Living) Status: .Transfers: 2 person assist.Weight Bearing: Non-weight bearing.Bed Mobility: 1 person assist.Ambulation: Bedrest. 4/6/26: Nurses Note: .Writer walked into room to change the dressing on her bottom; the resident was laying flat on her back with her leg propped up on the air conditioner. Residents (Certified Nursing Assistant- CNA) was in the room with her. CNA stated that she turned the resident on her side to be changed but then realized she needed new dressings. CNA stated that she told the resident she would be right back, came and told writer and went back into the room.She didn't realize the CNA was out of the room she said she was saying I'm slipping as she was falling.Resident was sent to the hospital. (Authored by Nurse T) 4/7/26: Orthopedic Surgery/Hospital Records: .(R121).presents after a fall out of bed today at nursing home.states she has been bed-bound for 8 months.Imaging: XR (x-ray) right hip obtained and immediately reviewed.demonstrates a displaced subcapital femoral neck fracture (fracture where the bone breaks directly beneath the ball/head of the thigh bone).admit to Orthopedic surgery. 4/15/26: History and Physical: .(R121).had fall from bed resulting in R (right) femoral neck fracture.no surgery d/t (due too) wounds and non-ambulatory status.pain control-scheduled Norco (pain medication). A review of R121's Incident/Accident (IA) report and investigation form noted the following: .Fall.Date: 4/6/26.Resident (R121).Incident Description:.CNA turned the resident on her side to get changed and realized she needed dressing for her bottom she came to tell writer she needed new dressings and went back to room to the resident being on the floor.Description: IDT (inter-disciplinary team).interventions are to provide education to staff on safety and positioning in bed. Staff educated on not to leave resident on her side if assistance is needed, she can press call light – Staff should make sure resident is middle of bed and in comfortable position.1 to 1 education: Employee (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	06/10/2026

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	Name (CNA U) Subject: Resident was left on side of bed with bed in high position during resident care. Staff left the room before placing resident in safe position which resulted in resident falling with injury. Best practice states to ensure resident safety by staying with resident and/or placing resident in safe position with low bed prior to leaving bedside. On 6/9/26 at approximately 3:31 PM a phone interview was conducted with Nurse T. Nurse T was queried as to R121's fall on 4/6/26. Nurse T reported CNA U was changing the resident and realized that they needed a dressing change and left the resident on their side to report their concern to them. Nurse T then went to the room and found R121 on the floor complaining of hip pain. Nurse T reported that CNA U never should have left the resident on their side with their bed in a high position. On 6/9/26 at approximately 3:37 PM a phone interview was conducted with CNA U. CNA U reported that they had been employed by the facility for approximately four months. When asked about R121's fall that occurred on 4/6/26, CNA U reported that they were assigned to work on the floor where the resident resided but noted that that was not their usual assignment and was not that familiar with the resident. CNA U stated that R121 needed a new patch on their bottom and they left the resident on their side to go and get the nurse. When they returned with the nurse the resident was on the floor. Following the fall, they were re-educated on not leaving a resident alone on their side and that they should have pressed the call light to have a Nurse respond. On 6/10/26 at approximately 9:31 AM, the Director of Nursing (DON) was interviewed about the incident. The DON reported that they were not employed by the facility at the time of the incident. However, when they were made aware of the fall, they noted that R121 should never have been left alone on their side. On 6/10/26 at approximately 1:42 PM, the Administrator was interviewed regarding R121's fall on 4/6/26. The Administrator reported that they were aware of the incident and CNA U should never have left the resident alone. The facility policy titled, Fall Management (7/8/25) was reviewed and documented, as follows: Policy: The facility will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls .Fall refers to unintentional coming to rest on the ground, floor or other lower level .If a resident rolled off a bed or mattress that was close to the floor, this is considered a fall . R79 On 6/8/26 at 11:08 AM, R79 was observed seated in a wheelchair wearing navy blue pants and a white shirt that were visibly soiled with emesis. Emesis was also observed on the floor near the resident. A suction machine with inline suction tubing was present on the resident's bedside table. When asked what had occurred, R79 stated, I choked this morning and they had to stick that tube deep down my throat to get it all out. The resident further stated that she felt better following the incident. A review of the medical record revealed that R79 was re-admitted to the facility on [DATE] with the admission diagnosis of Dysphagia oral phase, Lack of Coordination and Other symptoms and signs concerning food and fluid intake. R79 had a brief interview for mental status score of 10 which indicates mild cognitive impairment. (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	06/10/2026

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	On 6/8/26 at 12:43 PM, an interview was conducted with the Nurse Practitioner (NP), the NP reported that nursing staff notified them that R79 had been vomiting and that there were streaks of blood present in the emesis. The NP stated that the resident had food lodged in her throat and required suctioning after reportedly placing too much oatmeal in their mouth, resulting in choking and vomiting. The NP reported that they ordered a chest x-ray and notified the physician as a precautionary measure, and to have the staff just monitor R79. The NP was asked whether R79 required meal supervision or assistance. The NP stated that the resident did not require meal assistance and reported that this was the first choking incident of this nature involving the resident. On 6/9/26 at 10:30 AM, a review of R79 medical record revealed no nursing notes, progress notes, incident reports, or documentation describing the choking episode, vomiting, suctioning intervention, or subsequent resident assessment. A review of the resident's care plan revealed a focus area dated 11/25 indicating, Resident trialed on mechanical soft diet following MBSS (Modified Barium Swallow-a test to view how well a person can swallow), unable to tolerate due to eating too quickly; diet downgraded to pureed texture. The care plan goal stated, Will tolerate modified consistency diet as evidenced by no episodes of pain while swallowing, coughing, choking, pocketing, or signs/symptoms of aspiration through next review date. On 6/9/26 at 10: 45AM, an interview was conducted with the Director of Nursing (DON). The DON was asked whether she was aware of R79 choking incident on 6/8/26 that reportedly required suctioning intervention. The DON stated that she was made aware hours after the incident had occurred. The DON was further asked what her expectations would be if a resident experienced a choking episode requiring suctioning. The DON stated that nursing staff should assess the resident, notify the physician and responsible party as appropriate, monitor the resident for signs and symptoms of aspiration or other complications, complete nursing documentation regarding the event and interventions provided, and update the resident's care plan if indicated. The DON further stated that an event of this nature should be documented in the medical record so that the resident's condition could be monitored and the interdisciplinary team could evaluate whether additional interventions were necessary to prevent recurrence. The DON reviewed the medical record and was unable to locate nursing documentation related to the choking episode, however the NP did put in a note for the resident's vomiting (after the interview with surveyor), including the suctioning intervention. The DON acknowledged that the record did not reflect the facility's expected process for documenting and evaluating a significant choking event.

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	06/10/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #3014976Based on interview and record review the facility failed to ensure a resident received necessary physician ordered medication upon admission for one (R129) out of one resident reviewed for significant medication errors. Findings include: A complaint was filed with the State Agency (SA) that alleged R129 was not receiving needed treatment and medication and the failure to receive them resulted in sepsis and death.A review of R129's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: left hip fracture requiring operative repair , scoliosis and chronic back pain.Continued review of R129's clinical record noted the following:4/2/26: Hospital Discharge Order Sheet: History: .patient (R129) underwent hemiarthroplasty of the left hip on December 1, 2025 followed by multiple dislocations.A subsequent occurred on February 10, 2026.Persistent drainage from the surgical site has been ongoing for approximately three months.patient reports significant pain in the left leg.Discharge Summary (4/3/26).Start taking these medications: Abx (antibiotics): zerbaxa (intravenous antibiotic): Inject 3 g (gram) into the vein every 8 (eight) hours. stop date 4/27/26.Eravacycline (antibiotic used to treat complicated infections) Inject 80 mg (milligrams) into the vein every 12 (twelve) hours.stop date 4/27/26. Fluconazole (antibiotics): Take 3 tablets (450 mg) by mouth daily.stop date 4/27/26).4/3/26: Encounter:.Patient was admitted last night: 1. Zerbaxa IV ((intravenous) 3 G (Grams) every 8 hours.2. Fluconazole 150 mg (milligrams) -3-q (every) day.'. *The Eravacycline/Xerava was noted in this list.A review of R129's initial orders noted, in part, the following:4/6/26: Ceftlolozane -Tazobactam Intravenous Solution(Zerboxa) use 3 gram intravenously every 8 hours for wound. *There were no orders for this medication starting 4/3/26 when R129 was admitted .4/6/26: Eravacycline Dihydrochloride Intravenous Solution use 80 mg intravenously every 12 hours for wound. *There were no orders for this medication starting 4/3/26 when R129 was admitted .A review of R129's Medication Administration Record (MAR) for April 2026 was reviewed and noted as follows:Eravacycline : 4/6/26 9PM (not available) and 4/7/26- 9AM (not available)Ceftlolozane: 4/6/26- 2 PM (not available), 10 PM (not available)On 6/10/26 at approximately 9:32 AM an interview was conducted with the Director of Nursing (DON). The DON was queried as to why the two IV antibiotics (Eravacycline and Ceftlolozane) were not ordered and available when R129 was admitted to the facility on [DATE] and additionally why the same medications that were ordered on 4/6/26 were not available until 4/7/26. The DON reported that they were not employed by the facility at that time but would investigate the concern. The DON also noted that when they started employment at the facility, they noticed some concerns regarding medication orders and administration.On 6/10/26 at approximately 3:21 PM a second interview was conducted with the DON. The DON reported that they were not certain as to why R129 did not receive their intravenous antibiotics 4/3/26 through 4/7/26.On 6/10/26 at approximately 4:01 PM an interview was conducted with the Administrator regarding the delay in R129 receiving intravenous antibiotics. The Administrator reported that (name redacted) hospital does not send medication with the resident(s) upon discharge. *It should be noted that the hospital the Administrator mentioned was not the same hospital where R129 was treated. The Administrator was asked even if the hospital could not send the resident with needed medications what caused the delay in obtaining it upon their admission and/or if the facility was not able to obtain it timely why was the resident accepted to the facility. The Administrator reported that they were not certain what caused the long delay.The facility policy titled, Physician's Order (Revised 8/20/25) was reviewed and documented as follows:.Purpose: Physician orders are obtained to provide a clear direction in the care of the resident.On a regular basis or as required by state and/or federal law the attending physician will review the plan of care, including physicians orders.admission Physician orders not signed timely will be identified by the facility for physician signature.

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	06/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interviews and record reviews the facility failed to maintain an ongoing Infection Control Program, ensure consistent and accurate surveillance of the facility's infections and failed to consistently implement the facility's Infection Prevention Program policy, this had the ability to affect all residents' that resided in the facility, including R31.Findings include:A review of the facility's Infection Surveillance Program (December 2025 to May 2026) revealed the following:December 2025, January 2026, February 2026, March 2026, April 2026, and May 2026 - documented multiple Infection(s) as unknown with no signs/symptoms documented, however noted multiple antibiotics and other treatments administered to the residents.Infection Surveillance from December 2025 to May 2026 also noted multiple residents with signs/symptoms of chills, cough, shortness of breath, congestion, fatigue, nausea, vomiting and diarrhea - that were not tested for COVID-19 as recommended by CDC (Centers for Disease Control and Prevention) Symptoms of COVID-19 | COVID-19 | CDC.A review of the CDC Infection Control Guidance: SARS-Cov-2 dated 6/24/24, documented in part . This guidance applies to all U.S. (United States) settings where healthcare is delivered, including nursing homes. Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible. Infection Control Guidance: SARS-CoV-2 | Covid | CDC).A review of the January 2026 infection surveillance, failed to identify R31 to have returned from the hospital on 1/29/26 with diagnoses that included scabies, as noted in the hospital documents provided to the facility. The resident was released with a medication Permethrin (Elimite)- treatment for the scabies. A review of the February 2026 infection surveillance documented in part, . (R31's name). Infection Unknown. Permethrin External Cream 5% .Further review of R31's medical record revealed the resident was treated in December 2025 at the facility on 12/11/25 with Calamine External Lotion (over the counter medication) for a rash and Diphenhydramine HCl (Benadryl) cream on 12/24/25 for itching.Further review of the surveillance data revealed multiple residents treated for skin concerns.A review of the facility's policy titled Infection Prevention Program revised 2/28/25, documented in part . The infection prevention and control program (IPCP) must include, at a minimum, the following elements. Investigates, identifies, prevents, reports and controls infections. There is on-going monitoring to identify possible communicable disease or infections among residents and staff and subsequent documentation of infections that occur. Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks. Infection Preventionist. serves as the coordinator of an Infection Control program. Collecting, analyzing, and providing infection data. Consulting on infection risk assessment, prevention, and control strategies.On 6/10/26 at 10:59 AM, an interview was held with the Infection Preventionist (IP) G. The concerns of the facility's Infection Surveillance were discussed for the months of December 2025 to May 2026. IP G reported they were newly hired as the Infection Preventionist on 6/1/26. IP G reported they had identified many issues with the Infection Surveillance Program and started the work on correcting the Infection Surveillance in the facility moving forward. IP G was asked to provide any additional information or documentation for the concerns identified for R31. At 1:22 PM, IP G returned and stated they were unable to provide any additional information or documentation for the concerns regarding the concerns discussed.

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	06/10/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record reviews the facility failed to ensure ongoing oversight of the appropriateness of antibiotics and failed to ensure the criteria for infections were met, this had the ability to affect multiple residents that resided in the facility that was prescribed antibiotics.Findings include:A review of the facility's Infection Surveillance Program (December 2025 to May 2026) revealed the following:Multiple infections documented as unknown.Multiple infections noted without supporting documentation of the criteria of an infection to have been met.Multiple prescribed antibiotics for residents with no signs/symptoms documented.The Surveillance Program did not contain documentation to support the appropriateness of multiple antibiotics prescribed.On 6/10/26 at 10:59 AM, an interview was held with the Infection Preventionist (IP) G. IP G was asked how they determine if an infection met criteria for treatment and IP G stated the facility utilizes the McGeer's criteria. IP G was asked to provide documentation of the facility's infections to have met criteria and IP G reported they were newly hired as the Infection Preventionist on 6/1/26 and had identified issues with the program to not have contained all the required components. The concerns of the facility's oversight of the Antibiotics in the facility were discussed for the months of December 2025 to May 2026. IP G reported they had also identified the same concerns and had started the work on correcting the Antibiotic Stewardship program in the facility.Review of a facility policy titled Infection Control Antibiotic Stewardship & MDROs revised 4/17/25, documented in part . Antibiotic Stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials. The program will encourage appropriate prescribing. to help ensure antibiotics are prescribed only when appropriate. The facility has adopted McGeer's criteria for infection surveillance. The facility will communicate with the physician based on guest/resident history, evaluation, signs and symptoms, and diagnostic tests if applicable of suspected guest/resident infections to determine the best course of treatment.