

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Regency at Troy		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3069088. Based on interview and record review, the facility failed to ensure a dental evaluation was completed in a timely manner for one resident (R901) of two residents reviewed for Nutrition, resulting in continued oral pain, facial swelling, delay in starting speech/language pathology therapy (SLP) and subsequently being kept on a pureed diet. Findings include: On 7/22/26 a concern submitted to the State Agency was reviewed which alleged R901 was unable to eat properly and did not receive the appropriate treatment for mouth pain. On 7/22/26 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE] and was discharged to the hospital on 6/27/26 and did not return. R901 had diagnoses that included Type 2 Diabetes with foot ulcer and Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 5/28/26 revealed R901 needed assistance from staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was 11 which indicated moderately impaired cognition. A review of R901's care plan revealed the following: Focus-[R901] has alteration in nutritional and/or hydration status r/t (related to) PMH (previous medical history): HTN (Hypertension), DM (Diabetes Mellitus), CVA (stroke) with aphasia, HLD (Hyperlipidemia), Depression, learning disorder, seizure disorder. Recent weight loss during hospital stay with N/V (nausea/vomiting). BMI (body mass index) in the obese range. Hx (history) of being treated for oral thrush. Per nutrition risk screen resident is at risk for malnutrition. 3/10 . c/o (complains of) mouth pain - dental consult placed. Dislikes pureed food, SLP to screen once seen by dentist Per nutrition risk screen resident with moderate protein calorie malnutrition 4/14 returned from the hospital with ~3# (pounds) weight loss, dental consult in place for mouth and sinus pain .Date Initiated: 12/05/2025 .A Physician's order dated 12/2/25 revealed the following: Dental evaluation and treatment as indicated.Nurses note dated 12/7/25: Patient complains of pain in right side of the face, affecting her ability to chew food. Downgraded to full liquids after patient chose to only drink ensure all weekend, despite effort by Nurse to try puree and different type of textured foods.Physician progress note dated 12/8/25: .Seen today for follow-up UTI (urinary tract infection) and follow-up mouth pain .has been having oral pain. On exam patient missing multiple teeth and white patches consistent with Candida stomatitis (oral fungal infection). She reports for the past eight days she has been having oral pain discussed with nursing ensure patient is rinsing her mouth post administration .Assessment and Plans-Candidal stomatitis: Reports oral discomfort, white patches in mouth noted. Start oral nystatin swish/swallow ensure pt (patient) rinses mouth after inhaler use. Monitor for acute change .Dietary note dated 12/10/25: Resident dislikes pureed texture food, SLP following. Ensure ordered TID (three times a day) with meals which she accepts well Would also like to try magic cup with meals for added nutritional support. Continues to report facial (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0791 Level of Harm - Actual harm Residents Affected - Few	swelling/puffiness and mouth pain r/t thrush Nurses note dated 12/17/25: Patient and family concerned with difficulty swallowing, patient complains <sic> of sore throat when swallowing <sic> .Physician progress note dated 12/20/25: .Her mouth is dry and having creamy white patches on the tongue. When assisting her drinking water, she seems having pain during swallowing .Discuss with her to order nystatin mouthwash for the fungus infections and encourage fluid intake .Physician History and Physical dated 12/30/25: .was resident in facility and was rehospitalized for sepsis with source unclear-pulmonary vs (verses) oral infection and was treated with IV (intravenous) ABX (antibiotics) .Assessments and Plans-Sepsis, Unspecified Organism: Source pulm (pulmonary) vs oral giving poor dentition .Nurse Practitioner (NP) progress note dated 1/1/26: .was recently sent to the hospital due to facial pain and swelling. She was found to have leukocytosis secondary to odontogenic infection (infection of the tooth or surrounding tissues) and received antibiotics .Her tongue is pinkish without cottage cheese like appearance and continue nystatin mouth wash .Nurse Practitioner progress note dated 1/5/26: .Her lips dry and skin peeling. NP encouraged hydration and continue nystatin mouth wash Assessment and Plans-Encounter for dental exam and cleaning w/ abnormal findings: Still patient has dry lip and mouth infection .Nurse Practitioner progress note date 1/6/26: Writer summoned to patient room for c/o (complaints of) difficulty swallowing and sinus pain .She complains facial swelling and pain. She also c/o (complaints of) food getting stuck when she eats with difficulty swallowing .Patient some swelling to bilateral cheeks. On light palpation, patient has pain to Ethmoid and maxillary (upper teeth) since bilaterally. Patient attempting move writers hands stating Pressure hurts. Treatment: Doxycycline (antibiotic) 100mg (milligrams) BID (twice daily) x five days .Discussed with SPL .for evaluation and treatment for swallow issues .Nurses note dated 1/6/26: Resident was c/o face swollen and pain when she eats ans <sic> swallow. New orders were put in SLP twice weekly, diet change to regular texture, puree and thin liquids. Doxycycline 100 twice a day.Nutritional Evaluation dated 1/6/26: .Diagnoses: Facial pain and swelling .Current diet order-Regular diet, pureed texture, thin liquids .Nutritional risk & Recommendations- .Seen by SLP today and downgraded to a regular diet, pureed texture, with thin liquids. Visited resident at breakfast, didn't eat the biscuits and gravy at breakfast. Offered other options but she declined. Ensure on tray table which she consumed 100%. found to have thrush at the hospital, receiving nystatin SLP will follow for safest diet .Dietary note dated 2/1/26: Patient was complaining that she wants regular diet. She is currently on a puree diet and after eating she reported she is so hungry. She requested to be assessed by dietary and speech to possibly being changed to regular diet.Dietary note dated 2/5/26: Met with resident today. She confirmed she dislikes pureed food. Offered to increase other items with trays but she declined. Ensure TID (three times a day) ordered which she confirms she likes and accepts well. Message sent to SLP for screen to see if she is a candidate for a diet upgrade .Dietary note dated 2/5/26: Resident seen by SLP, unable to trial mechanical soft texture diet due to resident c/o dental pain and sinus pressure. Referred to Social Services to be seen by the Dentist and message sent to NP for eval for sinus pressure.Physician progress note dated 2/6/26:Per staff, complained of oral discomfort and swelling .Assessments and Plans- .Poor dentition and swelling noted oral care will start Augmentin BID oral intake as tolerated and monitor for any issues. Discussed with nursing-needs dental/omfs (oral maxillofacial surgeon) follow up .SLP Therapy note dated 2/6/26: Patient referred to SLP d/t (due to) disliking puree texture diet. Patient has already completed skilled speech therapy, throughout tx (treatment) patient refused mechanical soft texture trials or would spit out trials d/t (due to) difficulty chewing. Patient has reported since pain and dental pain since November-December 2025. This has been reported to multiple RN (Registered Nurses) and [Nurse Practitioner] who has placed dental evaluation order on 12/20/25. (continued on next page)		

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F 0791 Level of Harm - Actual harm Residents Affected - Few	Until dental evaluation completed, Patient not indicated for further skilled ST (Speech Therapy) services. Nurse Practitioner progress note dated 2/11/26: .Seen for acute follow up visit .Patient has oral discomfort and swelling. Patient is on Augmentin ABT (antibiotics) for 10 days until 2/16/26 .SLP Interdisciplinary Therapy Screen dated 3/10/26: Patient referred to SLP again d/t disliking puree texture diet (last referral on 2/6/26). Patient has already completed skilled speech therapy, throughout tx (treatment) patient refused mechanical soft texture trials would spit out trials d/t difficulty chewing. Patient continues to report sinus pain and dental pain currently and since November-December 2025. This has been reported to multiple RN and NP previously, who has placed dental evaluation order on 12/20/25-however this continues to not be completed. Until dental evaluation completed, patient not indicted for further skilled ST services. Notified [Director of Rehab] and [Dietician]. SLP Therapy note dated 4/8/26: Patient referred to SLP again for puree diet level (last referral on 2/6/26, and 3/10/26). Patient continues to tolerate puree diet well, however multiple staff members continue to refer to SLP for possibility of upgrades. Patient has already completed skilled speech therapy in January 2026 and throughout tx patient refused mechanical soft texture trials or would spit out trials d/t difficulty chewing. Met with patient again this date to screen. Patient continues to report sinus pain and dental pain now and since November 2025, with difficulty chewing. This has been reported to multiple RN (Registered Nurse) and NP previously, who has placed dental evaluation order on 12/20/25-however this continues to not be completed. Until dental evaluation completed, patient not indicated for further skilled ST services. Again, notified [Director of Rehab] and [Dietician]. Dental Evaluation dated 4/22/26: .Teeth: Condition: Poor; Soft Plaque/Food Debris Buildup-Heavy .Hard Calculus Deposits-Heavy .[NAME] (Gingivitis) Infalm (inflammation)/Swollen, Bleeding Gums-Severe. Periodontal Condition-Poor. Risk for Caries- High .Treatment Notes- .Patient presents with retained roots, .refer to OS (oral surgery) for ext (extractions) of all remaining root tips .Action Required by Nursing Home Staff-Refer to MD(Medical Doctor)/OS (Oral Surgeon) for extraction of all remaining root tips .Dietary note dated 4/30/26: .Resident on a pureed texture diet which she dislikes. Recently seen by Dentist and is being referred out to an oral surgeon for removal of remaining roots. Will be able to be reassessed by SLP once dental work is complete .SLP Interdisciplinary Therapy Screen dated 6/9/26: .Patient referred to SLP again for puree diet level (last referrals on 2/6/26, 3/10/26, 4/8/26). Patient continues to tolerate puree diet well, however multiple staff members continue to refer to SLP for diet updates d/t patient not finishing or refusing some meals. Patient has already competed skilled ST in [NAME] 2026 and throughout tx patient refused mechanical soft texture trials or would spit out trials d/t difficulty chewing. Met with Patient again to screen. Patient continues to report dental pain now and since November 2025, with difficulty chewing. this has been reported to multiple RN, NP, dietary and Social Work previously, who placed dental evaluation on 4/22/26. [Dentist] states she found 'retained roots, refer to oral surgery for extractions'. See note for more. Until further dental/surgery completed, patient not indicated for further skilled ST services. notified NP, DON (Director of Nursing), DOR (Director of Rehab), family, Social Work and MDS (Minimum Data Set) RN.A secondary review of R901's medical record did not reveal any documentation that an appointment to an Oral Surgeon for extractions had been made during their stay at the facility. On 7/22/26 at approximately 10:15 a.m., during an interview with Registered Dietician F (RD F), RD F was queried reading R901's nutritional status during their stay at the facility. RD F reported R901 was ordered health shakes (two ensures with each meal) totaling six shakes a day because R901 did not like the pureed diet/foods. RD F further indicated R901 was not able to upgrade their diet from pureed level due to mouth pain and was a choking/aspiration risk due to stroke and seizure combination. Speech pathology worked with R901, but could not do much (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. This citation pertains to intake #3074446. Based on interview and record review, the facility failed to address concerns/grievances for one resident (R108) of one resident reviewed for grievances, resulting in verbalized frustration and lack of resolution for concerns/grievances. Findings include: On 7/21/26 from 9:18 AM until 9:40 AM, an interview was conducted in R108's room with Family Member 'D'. They verbalized numerous complaints/concerns including staff attitudes, wound care, pureed food not provided, and medications given late. They were asked if they reported their concerns to staff and said they had, numerous times. On 7/21/26 at 12:21 PM, an interview was conducted with the complainant, and they verbalized frustration with R108's care but primarily focused on R108 missing several doses of their IV (intravenous) antibiotic medication, and medications being administered late. They were asked if they brought their concerns to the attention of staff and said they had, several times but felt like staff, didn't listen to them. They further indicated on several occasions they called the facility's ADON (Assistant Director of Nursing) and verbalized concerns. They were asked if they had ever filled out a facility concern form and said they filled out numerous forms but did not feel it did any good because their concerns persisted. They were asked if facility staff ever followed up with the concern forms for their resolution and satisfaction and if they signed them and said, Those forms just go into a void. The complainant further reported they had a care conference a few weeks ago and said, I laid it all out. The complainant continued to say they verbalized numerous concerns during the conference and staff at the care conference said they were going to write it all down and send it to the DON (Director of Nursing) via e-mail. The complainant said they requested to be copied on the e-mail to the DON; but never received a copy. They went on to say two days after the care conference they met with the DON who denied receiving an e-mail from the staff in attendance at the care conference. A review of a document titled, Interdisciplinary Care Conference v1.1 - V 3 was reviewed and revealed a care conference for R108 was conducted on 7/7/26 and attendees included, Social Services, Family and an MDS (Minimum Data Set) Nurse (a nurse who monitors, assesses, and documents patients' health at a residential or long-term care facility). Section C. of the document read, .C. Nursing Summary .(Family Member Name, relationship), concerned with how resident is repositioned .wants IV ATB [sic] (antibiotic) to be extended to cover missed dosages . A review of R108's, Resident, Family, Employee, and Visitor Assistance Form(s) provided by the facility was conducted and did not reveal any forms submitted by Family Member 'D' or any forms for the concerns voiced at the care conference on 7/7/26. On 7/22/26 at 9:15 AM, an interview was conducted with Social Worker 'B' (who attended R108's care conference on 7/7/26). They were asked if they recalled R108's family having voiced any concerns at the care conference and said they did voice concerns. They were asked if they recalled anything specific and said they couldn't recall, but most of the concerns were regarding nursing services and MDS Nurse 'C' took notes and was supposed to send the concerns to the DON. They were then asked if they knew if Nurse 'C' relayed the concerns to the DON and said they did not know, and Nurse 'C' no longer worked at the facility. On 7/22/26 at 9:35 AM, an interview was conducted with the facility's ADON, and they were asked if R108's family member(s) ever verbalized any concerns to them regarding R108's care. The ADON said they had. The ADON was then asked if they filled out concern forms when they received concerns/complaints and said when the family verbalized concerns/complaints they did not consistently fill out the forms but knew they should have. On 7/22/26 at 9:59 AM, an interview was conducted with the facility's DON. They were asked if R108's family had ever voiced any concerns/complaints and said they had. They were asked if they filled out any concern forms and (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said when R108's family verbalized concerns they did not fill out the forms, rather; they tried to act on it at the time and fix the issues. On 7/22/26 at 12:07 PM, an interview was conducted with the facility's Administrator who explained that when a resident or family has a concern/complaint, staff were to fill out a concern form so it can be addressed. The Administrator acknowledged R108's family had verbalized many concerns, and the forms should have been filled out. A review of a facility provided policy titled, Care Program revised 7/8/26 was conducted and read, Purpose .To ensure the facility actively resolves any concerns/grievances submitted orally or in writing to the Administrator, Director of Nursing, or any other member of the facility's staff .Any resident, his or representative, family member, employee, or appointed advocate may file a concern/grievance without fear of threat or reprisal. All concerns/grievances are investigated, resolved, and documented .		