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	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Troy	2685 West Maple Road Troy, MI 48084

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to intake # MI00150969 Based on observation, interview and record review, the facility failed to treat residents with dignity and respect for three (R60, R52 and R318) of four resident reviewed for dignity. Findings include: Review of a facility policy titled, Resident Rights revised 5/14/24 read in part, .The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . Facility staff will assist residents in exercising their rights . R60 On 3/25/25 at 5:16 PM, R60 was observed sitting in a wheelchair, their Family Member (FM) V was sitting on R60's bed. R60 was asked about care at the facility. R60 explained the day before they needed to be changed, no one was answering the call light so they yelled out because the nurse station was near their room . a staff member came into their room and told them that they did not have enough patience and that she was just coming on to her shift. R60 explained they started to cry because of what the staff member had said and then the staff member told them to stop the fake tears. R60 was asked if they knew who the staff member was. R60 explained they did not know, but it was at shift change, and after it happened, the previous CNA (Certified Nursing Assistant) came in and apologized to them. Review of the clinical record revealed R60 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: heart failure, diabetes and hypertension. According to the Minimum Data Set (MDS) assessment dated [DATE], R60 had intact cognition and required the assistance of staff for activities of daily living (ADL's). Review of R60's incontinence care plan revealed an intervention revised 6/29/24 that read, Check prn (as needed) for incontinence. Wash, rinse and dry perineum. Change clothing after incontinence care as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/25 at 4:07 PM, R60 was observed sitting in a wheelchair in their room. R60 was asked again about the incident with the staff member. R60 explained their mind might be a little flaky, but they remembered they were not treated with respect and dignity. On 3/27.25 at 9:20 AM, CNA K, who was R60's assigned afternoon CNA on 3/24/25, was interviewed by phone and asked if there was an incident involving R60 on 3/24/25. CNA K explained he had an orientee he was training that afternoon, they went on break around 7:00 PM and came back around 7:30 PM . his orientee came to him and told him there had been a situation with taking R60 to the toilet while they were on break . asked the nurse who told him R60 had been screaming for 30 minutes and that no one was around so she had to take R60 to the toilet and change them herself even though she was the nurse and he was the CNA. CNA K was asked the name of his orientee and the nurse. CNA K explained the nurse was LPN L, but could not remember the name of the orientee. CNA K was asked if he spoke with R60 after he came back from break. CNA K explained he had and R60 told him the staff member who had changed them had yelled at them and made them cry. When asked if he had told anyone what R60 told him, CNA K explained he had told LPN K and the Afternoon Supervisor. On 3/27/25 at 9:26 AM, LPN L was interviewed by phone and asked what happened with R60 on 3/24/25. LPN L explained she was not R60's nurse, but while getting report at the start of her shift, she heard R60 screaming, she thought they had fallen or was hurt . when she went in, R60 was soaked through their clothing . told R60 they did not have to scream . took them to the toilet and R60 said they needed a shower . told R60 it was shift change and someone would come in to help them a little later . when CNA K and his orientee came back from his break I told him they should have changed R60 before their break. LPN L was asked the name of the orientee. LPN L explained it was CNA M. On 3/27/25 at 9:45 AM, CNA M was interviewed by phone and asked about the incident with R60. CNA M explained it was her first day at the facility, when she and CNA L returned from their break, she was told R60 was upset and needed to be changed so she went in and R60 and their Family Member were both upset . the Family Member told her they had already changed R60 . told the Family Member she had checked R60 before her break, but they did not need to be changed, they only wanted their television turned on . the Family Member told her they were not upset about R60 needing to be changed, but that someone had yelled at R60 . asked R60 if they knew who it was, or what they looked like . R60 told her it was the person just starting their shift . told CNA K who told LPN L . LPN L started yelling at CNA K and was trying to paint the picture that we did not take R60 to the toilet or change them before we went on break . LPN L was very aggressive toward CNA L. On 3/27/25 at approximately 2:15 PM, the Assistant Administrator, who was acting as the Administrator, was interviewed and asked about the incident involving R60 on 3/24/25. The Assistant Administrator explained LPN L was being investigated for customer service concerns. R52 On 3/25/25 at 10:43 AM, R52 was observed sitting in a common area. R52 was asked about care at the facility. R52 explained the staff at the facility did not wear name tags and they did not know any of the staffs names . if they asked the staff their name, how did they know that was truly their name, they could just say any name. On 3/25/25 at 10:45 AM, observation of the staff on R52's floor revealed the staff not wearing name tags, some had their name written on a piece of tape on their shirt and/or jacket. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 12:00 PM, observation of the first floor dining room revealed the staff not wearing name tags. Review of the clinical record revealed R52 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease, anxiety disorder and major depressive disorder. According to the MDS assessment dated [DATE], R52 was cognitively intact and required the assistance of staff for ADL's. On 3/26/25 at 12:05 PM, CNA P was interviewed and asked about not wearing a name tag. CNA P explained they had worked at the facility for two weeks, and did not have one yet. CNA P was asked about the staff wearing tape with their name on it the day before. CNA P explained they had been told to write their name on tape yesterday because of the survey. When asked if the staff normally wear tape or name tags, CNA P explained usually only the nurses wore name tags, the other staff did not wear any identification. On 3/26/25 at 12:10 PM, CNA R was interviewed and asked about not wearing a name tag. CNA R explained it had fallen off. It should be noted, CNA R was not observed wearing a name tag prior to the interview, or the rest of the afternoon after the interview. On 3/26/25 at 12:19 PM, CNA Q was interviewed about not wearing a name tag. CNA Q explained they did not have one yet . had called Human Relations about it . at all previous jobs it was required . knew it was important for the residents' to know who they were. On 3/27/25 at 10:01 AM, the Assistant Administrator was interviewed and asked about the staff not wearing name tags. The Assistant Administrator explained there had been an issue with new staff getting name tags, but all staff were expected to wear their name tag as part of their uniforms. 40330 R318 On 3/25/25 at 2:35 p.m.,R318 was observed in their room lying in their hospital bed. R318's Family Member, FM DD, was seated in a chair in their room. R318 reported they wanted FM DD to assist to answer questions with them. Review of R318's MDS assessment, dated 3/19/25, revealed R318 was admitted to the facility on [DATE], with diagnoses including influenza, heart failure, and kidney failure. The assessment revealed R318 required assistance with ADLs and was cognitively intact. On 3/25/25 at 2:38 p.m., FM DD reported a staff member sometimes had an attitude toward R318 when they needed to be changed (their brief). Both reported the aide treated them roughly when they needed to be changed, which upset them. FM DD clarified they wished the staff would be gentler during cares with R318. FM DD reported the aide who concerned them seemed like they were not enjoying their job. Both denied any abuse or abusive treatment. Both reported they wanted their concerns reported. This Surveyor immediately followed up with their nurse, who reported they would notify the Administrator immediately. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 3:34 p.m., the Nursing Home Administrator (NHA) asked to follow-up with Surveyor in R318's room. The NHA reported, with FM DD present, they had reviewed their concerns further and determined FM DD had concerns with a nursing aide having an attitude with their spouse. FM DD confirmed their concerns were about an unnamed staff member's attitude towards their spouse, which bothered them. The NHA reported they would follow-up regarding their concerns.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to accommodate a resident with the appropriate bed for one Resident (R92) of two residents reviewed for accommodation of needs. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 3/10/25, revealed R92 was admitted to the facility on [DATE], with diagnoses including asthma, atrial fibrillation (heart rhythm disorder), anxiety, and depression. R92 required maximal assistance with bed mobility and was dependent for toileting. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R92 was cognitively intact. R92 was 67 tall (5', 7) and weighed 281 pounds. On 3/25/25 at 12:57 p.m., R92 was observed in a bariatric hospital bed, wearing a gown. R92 was wearing oxygen via a nasal cannula, with their head of bed elevated. Their feet were observed resting on the wooden footboard of their bed. On 3/25/25 at 1:00 p.m., R92 stated, My bed is too short. R92 reported they slid down in their bed often and had to keep the head of their bed up due to asthma. R92 reported they had to frequently call nursing staff to reposition them, which was frustrating, as they felt a longer bed would resolve the problem. R92 reported they were calling the nursing staff again at that time to reposition them up in their bed. On 3/26/25 at approximately 5:00 p.m., R92 was observed with Licensed Practical Nurse (LPN) EE lying in their hospital bed, with the head of the bed elevated, per their preference. R92 was observed with their feet directly touching the wooden footboard of the bed. R92 reported this bothered them. LPN EE assisted R92 to reposition their feet, and Surveyor and LPN EE observed R92's feet. A large quarter-sized bright red area was observed on the dorsum of R92's left foot pad, directly where their foot made contact with the bed. LPN EE reported to R92 they would work on getting them another bed. This Surveyor asked R92 how they felt about their hospital bed and their feet striking the footboard. R92 stated, I feel like cutting the foot of my bed off. This Surveyor asked if they had told any staff about their concerns. R92 reported they had told the Administrator, who was off this week, and their nurses. R92 clarified nothing had been done to provide them a taller hospital bed, which was upsetting to them, as this had been occurring since they were admitted to the facility. Review of the EMR (electronic medical record) on 3/27/25 at approximately 3:00 p.m. showed no documentation of any skin assessment, wound assessment, skilled nursing charting, daily notes, change in status note, or other documentation to reflect nursing assessment and follow-up. There was no documentation found related to obtaining an alternate bed for R92. On 3/27/25 at 4:16 p.m., the concerns regarding R92's bed being too short, the lack of follow-up, and the lacking nursing documentation related to the red area on R92's foot were reviewed with the acting Director of Nursing (DON). The DON reported they did not see any nursing assessments or documentation related to the concerns in the EMR. The DON stated first they would follow-up with the nursing staff, and then they would follow-up with maintenance staff, and reported they understood the concerns, as they would have expected to see documentation in the EMR regarding both concerns. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Skin Management, revised 8/14/24, revealed, Policy: It is the policy that they facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries .Practice Guidelines: 9. The licensed nurse will monitor, evaluate, and document changes regarding skin condition to include: dressing, surrounding skin, possible complications and pain in the medical record . An accommodation of needs policy was requested on 3/27/25 via email, and not received by survey exit.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 38271 Based on interview and record review, the facility failed to ensure that grievances/concerns were promptly documented, investigated, tracked and resolved for two residents (R7 and R60) of six residents that participate in the resident council (RC) meetings. Findings include: On 3/26/25 at approximately 11:03 a.m., during the group meeting, the group of residents was queried if the facility had provided resolution to the concerns they were bringing to the regular resident council meetings. R60 reported they were unaware of the plans were to fix any of the issues they bring up in resident council because nobody tells them what they are doing. R7 reported the facility staff just tell them they will fix it and do not follow-up with the council on how, which is why call lights response is an issue every month. On 3/26/25 a review of the previous six months of resident council minutes was conducted and revealed the following concerns noted by the residents: 1. Date of meeting-10-24-24 .New Business: .Hskpg (housekeeping)./Laundry - Occasional long wait for returns of personal .*Nursing -Long call light wait - Concern form (Ongoing) - Call lights turned off w/o (without) concern addressed - No badges on some staff - Concern form . 2. Date of meeting 12-26-24 .Dietary - Tickets not followed (Preferences, Allergies Condiments/Silverware missing - Concern form *Hskpg./Laundry - No issues *Nursing -Long call light wait - Concern form (Ongoing) - Call lights turned off w/o concern addressed Concern Form (Ongoing) - Peers wandering into rooms (New) - Concern form 3. Date of meeting-1-23-25 .New Business: .*Nursing -Long call light wait - Concern form (Ongoing) - Call lights turned off w/o concern addressed - Concern Form 4. Date of meeting-2-27-25 .New Business: .*Nursing -Long call light wait - Concern form (Ongoing) - Call lights turned off w/o concern addressed - Concern Form (Ongoing) On 3/27/25 at approximately 2:56 p.m., The Assistant Administrator and the RDO (Regional Director of Operations) were queried for documentation of the resolution of the concerns that the resident council had provided to them. The RDO and Assistant Administrator both indicated they had no documentation that the concerns noted in the resident council minutes had been documented, addressed and resolved. No concern forms/grievances documenting the resident council's concerns for the noted months were provided by the end of the survey.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to ensure Nursing standards of practice were followed for medication administration for one resident (R7) of one residents reviewed for pain management. Findings include: On 3/26/25 at approximately 11:01 a.m., during the resident council meeting, R7 indicated that they had an issue with the facility failing to ensure they received their pain medications. R7 indicated the facility had run out of their medication on multiple occasions. On 3/26/25 the medical record for R7 was reviewed and revealed the following: R7 was initially admitted to the facility on [DATE] and had diagnoses including Congestive heart failure and Chronic kidney disease. A review of R7's MDS (minimum data set) with an ARD (assessment reference date) of 1/18/25 revealed R7 needed assistance from facility staff with most of their activities of daily living. A review of R7's comprehensive plan of care revealed the following: [R7] is at risk for pain r/t (related to): Anemia,Impaired mobility, DM (Diabetes Mellitus), CKD (Chronic kidney disease), Hemiplegia and hemiparesis affecting Right side, limited mobility .Date Initiated: 10/13/2024 A Physicians order dated 11/28/24 revealed the following: Norco Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug* Give 1 tablet by mouth three times a day for Pain A review of R7's March 2025 Medication Administration Record (MAR) revealed R7 was not administered their norco pain medication on the evening of 3/14 and 3/15 (2200 doses). An EMAR (electronic medication administration record) note for R7's 2200 dose documented in part, the following: 3/14/2025-22:37-Per pharmacy resident needs a new c2 script, NP (Nurse Practitioner) on-call notified . A second EMAR note for R7's 2200 Norco dose revealed the following: 3/15/20252-1:08-on order On 3/26/25 at approximately 1:23 p.m., Nurse manager D (NM D) was queried why R7 did not have their medications administered on the evenings of 3/14 and 3/15 and they reported that the medication had ran out at that time and they sent a prescription to get filled for a new delivery from the pharmacy. NM D was queried what the process was for ensuring R7 was administered their medications and they indicated that the Nurses should have reordered the medications earlier and called the pharmacy to get an authorization to pull the backup Norco from the backup supply system. NM D was queried for backup supply report for R7 and they indicated they would look into it. On 3/26/25 at approximately 2:31 p.m., during a follow up conversation with NM D, NM D indicated that the there was not documentation that R7 had their evening Norco doses administered from the backup supply. NM D reported that documentation for the morning and afternoon doses were present in the report but nothing for the evening doses on 3/14 and 3/15. NM D Stated that the Nurses for those administration times, should have followed the same process of securing authorization and pulling medication for administration that occurred for the morning and afternoon dose of the Norco. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 a facility-provided document titled Keys to Success to Receive STAT (ASAP) Medications Timely was reviewed and revealed the following: STAT medication ordering process .Order received and communicated to Remedi. Pull first dose from on-site back-up (Cubex) .Call the pharmacy: if the medication is needed STAT (not in on-site back-up) .If the medication is needed before the next routine delivery . Pharmacist will assist you with determining what is needed and how it will be delivered .Must contact pharmacy prior to removing controlled medication from back-up supply .If the medication is needed STAT or before the next routine delivery and it is past your cut-off time, call the pharmacy. Pull the first dose from cubex .A pharmacist will assist you with determining what is needed and how it will be delivered (routine delivery, STAT, back-up pharmacy) .STAT should arrive no more than 4 hours after talking with the pharmacist .'Live' staff answer the telephone .even after normal business hours .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49083 This citation pertains to Intake #MI00151101, MI00150969 Based on observation, interview, and record review, the facility failed to ensure staff provided prompt response to answering call light requests for four (R7, R60, R17, R37) of four reviewed for Activities of Daily Living resulting in R7 left in a soiled brief for an extended period on 3/25/25 leading to concern of developing an infection. Findings Include: Clinical record review revealed R7 was admitted to the facility on [DATE] with a history of stroke resulting in impaired mobility with right sided weakness, COPD (Chronic Obstructive Pulmonary Disease) and diabetes. R7 was identified as incontinent of bladder and bowel and had a history of Urinary Tract Infections (UTI's). Brief Interview of Mental Status (BIMS) dated 1/18/25 revealed R7 scored 14/15 indicating no cognitive impairment. On 3/25/25 at 10:09 AM, during initial introduction, R7 voiced concern that they had been lying in bed with a soiled brief for hours and that the staffing is so bad, this happens daily. R7 stated they had placed their call light on around 8:00AM, a nurse came in, and said they would send down a Certified Nurse Assistant (CNA) they turned off the call light and said they would be back. R7 voiced concern that they had recently recovered from a UTI and was afraid they might have another one. When asked why they thought that, they indicated there was pain with urination and it smells bad. After the interview, R7 said they were going to try and get help once again. On 3/25/25 at 10:13 AM, R7 Placed their call light on. On 3/25/25 at 10:35 AM, the call light was observed on, and no staff acknowledged the call light. On 3/25/25 at 10:40 AM, a staff member wearing yellow was observed entering the room, and said they would be right back. On 3/25/25 at 10:45 AM, a different staff member wearing a teal-colored uniform was observed entering R7's room, the light in the hallway was turned off, and the staff member immediately exited the room. On 3/25/25 at 10:57 AM, no staff had returned to R7 since exiting at 10:45 AM and R7 was questioned what happened. R7 replied that another Certified Nurse Assistant (CNA) came into the room, and, I told them I had to be changed. They turned the call light off and said they would be back. R7 remarked that they did not wanted to place the call light on again because then you get a reputation, and they won't take care of you at all. On 3/25/25 at 11:22 AM, R7 was observed still lying in their bed and said they had not been cleaned up. They alleged a different CNA came in 10 minutes ago, said they would be back, but still nothing. R7 expressed frustration commenting they have urinated three times in the same brief since 5:00 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 12:06 PM, R7's room was observed with the door closed, upon entering, R7 was up in their wheelchair, their bedding was observed soiled, and a foul pungent urine smell permeated the room. 38271 On 3/26/25 at approximately 10:50 a.m., during the group meeting, the residents were queried if they had any concerns about being assisted with their activities of daily living. R7 reported that on multiple occasions, CNA's will come in to answer their call light request for assistance and will turn the light off, then leave and do not come back and they are left in the bed needing care. R7 reported this happens on a daily basis in the evening when management leaves. At that time, R60 and R37 agreed with R7 and both residents indicated they have had delays with care. 39592 R60 On 3/25/25 at 9:25 AM, R60 was observed sitting in a wheelchair in their room. R60 was asked about care at the facility. R60 explained it could take a long time for staff to answer the call light when they pushed it . since they were near the nurse station they would start yelling for help so they would not soil themselves . some of the staff did not like it that they yelled, but sometimes it was the only way to get help when they needed it. Review of the clinical record revealed R60 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: heart failure, diabetes and difficulty in walking. According to the Minimum Data Set (MDS) assessment dated [DATE], R60 had intact cognition and required the assistance of staff for ADL's. R17 On 3/25/25 at 9:53 AM, R17 was observed sitting on the side of their bed. R17 was asked how long it took for staff to answer call lights. R17 explained when they finally came, the staff would immediately turn off the light then ask them what they needed, then a lot of the time they would say they would be back before they did what was asked, and some would not come back. R17 pointed to the floor and explained they could be lying on the floor, and the staff would step over them to turn the light off before asked what was needed. Review of the clinical record revealed R17 was admitted into the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease, depression and anxiety disorder. According to the MDS assessment dated [DATE], R17 had intact cognition, and required the assistance of staff for ADL's.

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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** 49083 Based on observation, interview, and record review, the facility failed to transcribe and implement treatment orders as prescribed by the Physician for one resident (R18) reviewed of one resident reviewed for edema. Findings include: Clinical record review revealed R18 was admitted to the facility on [DATE] and required physical therapy for a decline in function from left shoulder surgery. R18 had a functional ability deficit related to stroke with left sided weakness which required assistance with self-care and mobility. R18 required diuretic therapy related to their history of hypertension and edema. The Brief Interview of Mental Status (BIMS) scored on 3/10/25 was 15/15 indicating R18 had no cognitive impairment. On 3/25/25 at 10:01 AM, R18 was observed in their room, sitting in a wheelchair watching television. Both lower extremities were observed swollen, shiny, and reddened with scattered dry scabs. Both legs were exposed (open to air) and observed with areas on the front and back of the calves with serosanguineous (fluid combination of bloody and watery drainage) drainage from open areas of the scabs. The drainage was dripping down the leg and into their shoes. R18 commented that their legs had been increasing in swelling and the drainage had become worse that their shoes are damp from the drainage. Review of the treatment record revealed that nursing was applying compression stockings every day for edema. When speaking with R18, no compression stockings were noted on the resident or visible within the room. Record review revealed on 3/25/25, an order was placed to wrap both lower extremities with dry gauze every day and as needed for skin weeping. Compression stockings be applied every morning and off at night. On 3/26/25 at 2:05 PM, R18 was observed in bed, legs were open to air, scabbed leaking and serosanguinous drainage on a light green throw blanket. When questioned if they had their legs wrapped since yesterday, R18 denied. When asked about their compression stockings, R18 said they had not been applied all week and said they had eight pairs which all were sent to laundry because they were stained with the drainage that was weeping from their legs. On 3/26/25, a record review of the Treatment Administration Record (TAR) revealed on 3/25/25 and 3/26/25 nursing documented the compression stocking were applied. The TAR did not record the new order placed on 3/25/25 to wrap the legs with dry dressing and gauze. Further record review of the order revealed nursing signed off the order on 3/25/25 at 12:52 PM but was not processed because the scheduling details of the treatment lacked the frequency and were not completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 4:29 PM, during an interview with the Assistant Director of Nursing (ADON) review of the treatment order written on 3/25/25 was reviewed and acknowledged nursing should have reviewed the order completely and treatments were missed because no frequency was indicated. The TAR and observations were discussed that nursing documented application of the compression stockings yet R18 denied having them applied in over a week and observations did not reveal compression stockings were applied as documented. The ADON concurred this was not acceptable. Informed the ADON an interview with the nurse who documented application on 3/26/25 was attempted, but the nurse was never available. The ADON said they would address. Review of the facility policy titled; Physician Orders dated 10/23 documented: .The licensed nurse receiving the order must verify to ensure the order is complete and that it includes: Accurate frequency .

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F 0686 Level of Harm - Minimal harm or potential for 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** 40330 Based on observation, interview and record review, the facility failed to provide adequate standards of care including lack of proper positioning and adequate documentation for two Residents (R81 and R312) of two residents reviewed for pressure ulcers. Findings include: R81: Review of R81's Minimum Data Set (MDS) assessment, dated 3/15/25, revealed R81 was admitted to the facility on [DATE], with diagnoses including stroke, dementia, quadriplegia, malnutrition, adult failure to thrive and seizure disorder. The assessment revealed R81 was dependent for all care, bed mobility, and transfers, and had seven pressure ulcers, with two not present on admission. It was noted R81 had a urinary catheter and an ostomy. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 3/15, which showed R81 had severe cognitive impairment. On 3/25/25 at 1:49 p.m., the wound care nurse, Licensed Practical Nurse (LPN) C, was asked about R81's wounds. LPN C confirmed two of their pressure ulcers were facility-acquired. On 3/26/25 at 9:34 a.m., LPN C was asked how R81 acquired the facility-acquired pressure ulcers. LPN C reported they had heard the midnight staff were not positioning R81 properly, which they could not confirm. LPN C stated they had done education on positioning with the midnight nurses. LPN C reported R81's wounds were improving. On 3/26/25 at 9:58 a.m., R81 was observed in their hospital air bed with LPN C. They were wearing a hospital gown, with soft blue positioning boots. R81 was staring ahead, awake, and agreed to the observation by whispering yes. R81 had an offloading wedge on their right side, however it had not offloaded them properly, as their skin made contact with the mattress. LPN C observed same, and agreed R81 was not adequately offloaded on their wedge cushion. LPN C and another nurse repositioned them by offloading them onto their left side with the wedge cushion placed on their back, to limit skin contact given the sacral (base of spine) and ischial tuberosity (base of pelvis) pressure ulcers. On 3/27/25 at 9:29 a.m., R81's wounds were observed with LPN C in their wound care documentation under the Wound Care tab in the Electronic Medical Record (EMR). This Surveyor had reviewed the wounds under Skin and Wound in the assessments section of the EMR. It was observed the names of the wounds and the measurements for R81's wounds did not fully match the wounds reviewed with LPN C, showing inconsistencies. It was also noted some of the wounds showed twice under the same name in the Skin and Wound documentation, appearing to be duplicate records. Both concerns affected the ability to follow the wounds back readily. LPN C observed with the wounds with Surveyor under their Wound tab, and the Skin and Wound assessments and reported they understood the concern. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at approximately 9:50 a.m., LPN C confirmed some of the wound pictures needed to be deleted and removed from the medical record. LPN C further clarified, I don't know how to delete them. Before we take (wound) pictures we need to make sure we are following the right picture . LPN C reported they understood this made it more challenging for the chronology of the wounds to be followed. LPN C understood the discrepancy with the wound care descriptions varying across records. LPN C reported they understood the concerns with the discrepancies, which could lead to inaccurate or incomplete wound care documentation. LPN C was asked if R81's facility-acquired pressure ulcers were avoidable or unavoidable. LPN C reported they were not sure, as there had been concerns about positioning brought to their attention. Review of the EMR (electronic medical record) received from the facility under the Wound tab showed R81's pressure ulcers were described on 3/25/25, with pictures, as follows: - Left Heel: Unstageable. Improving. Present on admission. 14.19 cm2. - Left Lateral Lower (front) leg: Stage 3. Improving. Present on admission. 6.51 cm2. - Left Rear Thigh: Stage 4. Improving. In-House Acquired. 14.19 cm2. - Right Medial Calf: Stage 4. Improving. Present on admission. 14.19 cm2. - Right Ischial Tuberosity: Stage 4. Improving. 9 months old. In-House acquired. 1.88 cm2. - Sacrum: Stage 4. Improving. Present on admission. 11.61 cm2. Review of the EMR showed no documentation of R81's wounds showing any current infection. Review of R81's profile showed Family Member (FM) LL was their responsible party and guardian. On 3/27/25 at 12:16 p.m., FM LL was asked about R81's wounds and wound care at the facility. FM LL reported per their observation's facility staff did not always position and offload R81 appropriately, which they believed led to the progression of R81's wounds. FM LL reported on 3/15/25 and 3/16/25, R81's daytime wound care was not completed on the day shift, as they checked on R81 more than once a day typically. FM LL stated, I just need them (nursing staff) to do what they are supposed to do; I am upset about this whole situation . FM LL explained R81 had wound infections in the past, and they did not want R81 to have another wound infection. FM LL also explained they had concerns regarding R81 not being positioned appropriately, stating, It does no good to put the wedge (directly) on the sacrum .Positioning has been the major issue . FM LL explained R81 needed to be placed on their side with the wedge on their back, not directly on their sacrum, due to the sacral pressure ulcer. FM LL reported sometimes they found R81's wound bandages wet, which concerned them. Review of R81's census revealed they were in the facility in March 2025, from 3/01/25 through 3/18/25, when they were hospitalized . R81 returned to the facility on [DATE] and was reviewed through 3/27/25. Review of the EMR revealed R81's wounds were described by different names. R81's Treatment Administration Record (TAR) was used as a point of reference, given the wounds named received daily wound care treatments, and their administration records. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R81's March (2025) TAR revealed R81 was being treated for six wounds, scheduled, each shift (two shifts), as follows: - Left heel, anterior and medial ankle - Left lateral leg - Left rear thigh - Right lateral calf - Right rear hip - Sacrum Further review of R81's March (2025) TAR noted there were also PRN (as needed) orders. The wounds and treatments described refer to scheduled wound treatments only. Review of the TAR revealed the Chart Code of 5 was described as '5' = Hold. See nurse's notes. Review of R81's March (2025) Treatment Administration Record (TAR) revealed missing wound care treatments documented for R81's six wounds as follows: 3/09/25: 5 Day shift 3/11/25: 5 Night shift 3/15/25: 5 Day shift 3/16/25: 5 Day shift Review of R81's EMR including nursing progress notes and documentation revealed no explanation for the missing wound care treatments during the month of March (2025). The missing wound care treatments on 3/15/25 and 3/16/25 corroborated FM LL's description of the missing wound care, on the weekend day shifts. Review of R81's EMR showed no documentation of why R81's facility-acquired pressure ulcers were unavoidable. On 3/27/25 at 3:52 p.m., the Director of Nursing (DON) was asked about R81's pressure ulcers, the development of facility-acquired pressure ulcers, and the missing wound treatments. The DON reported they understood the concerns. The DON shared LPN C did not complete all the wound care treatments, and the floor nurses were sometimes responsible to complete them, including on the weekends. The DON conveyed the staff needed continued training on treating and dressing more complex wounds, and going forward the unit managers would be doing wound care with the nurses and staff. Surveyor asked if the missing wound treatments would have affected the progression of R81's wounds. The DON stated they could not ascertain if there was an outcome from the missing wound treatments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R R81's March (2025) TAR with the DON showed the missing wound treatments this month. The DON confirmed they observed the missing wound care treatments and understood the concern. This Surveyor asked if R81's facility acquired pressure ulcers were avoidable or unavoidable. The DON reported they did not find this documentation in the medical record, or an explanation. The DON responded R81 would do best being on an air bed which tilted, like they had at the hospitals, and the bed R81 was not quite what R81 needed. The DON reported they had explored this option, and it was not covered in a SNF (Skilled Nursing Facility), as despite turning them frequently, the offloading did not seem to be helping enough for R81. The DON clarified R81 was medically fragile, and they would have done best in a hospital setting where they could be followed closely by a wound care physician and and infectious disease physician. The DON reported they understood the concerns and would be implementing education for staff, including making sure R81's wound bandages were kept dry and changed to prevent moisture. The DON reported they had discussed sending R81 to the hospital on several occasions with the family who had declined a transfer. The DON stated, (R81) may need a higher level of care . This Surveyor reviewed concerns regarding the documentation discrepancies between the Wound tab and Skin and Wound assessments, and duplicate entries for the same wound. The DON reported they understood the concerns and would follow-up with NP KK and LPN C, who were both documenting R81's wounds in the EMR. On 3/27/25 at 4:23 p.m., NP KK was asked about R81's wounds and wound care. NP KK confirmed R81 had developed two facility-acquired pressure ulcers, and indicated R81's medical comorbidities placed them at risk for the development of wounds and slower healing. NP KK indicated R81's wounds were improving and explained R81 needed to be positioned appropriately and offloaded frequently due to their wounds. NP KK indicated the facility-acquired pressure ulcers may have developed from positioning concerns, and an alternative bed and/or mattress may benefit R81, although it was unclear if it was in the budget. NP KK' reported they had discussed this with the facility and R81's family. R312: Review of the R312's Minimum Data Set (MDS) assessment, dated 3/16/25, revealed R312 was admitted to the facility on [DATE], with diagnoses including heart failure, kidney failure, femur fracture, and malnutrition. The assessment showed R312 required maximal assistance for bed mobility, and was dependent for transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which showed R312 was cognitively intact. The skin assessment showed R312 had one unstageable pressure ulcer present upon admission. On 3/25/25 at 12:03 p.m., R312 was observed lying in their hospital bed, with their Family Member, FM II , seated in their room. Their left heel was observed offloaded on a pillow. FM II stated almost every time they were at the facility, R312's heel was positioned on their mattress. FM II clarified this had happened again today (3/25/25), and they had placed R312's left leg on their pillow and offloaded their heel. FM II indicated this caused R312 pain and discomfort, and this concerned them. FM II clarified they did not want R312's heel pressure ulcer to worsen, and they wanted R312 to be able to successfully participate in therapy and make progress due to a recent fracture. On 3/25/25 at 12:08 p.m., R312 was asked about their left heel pressure ulcer. R312 reported their pain was 6 of 10 (with 10 the highest pain) when offloaded, and 10 and a half when their heel was not offloaded on the pillow. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 2:17 p.m., R312's left heel was observed resting directly on their bed. R312 was wearing gripper socks, with the bandage showing underneath. The bandage appeared to be over the left heel, in a pressure area. Soft pressure relief padded boots were observed in R312's room on R312's nightstand. R312 reported they did not like the heel boots and declined to wear them. Review of R312's Care Plan described R312's left heel wound as a diabetic ulcer. Review of R312's skin assessments showed the wound was reflected as a left heel diabetic ulcer on two of the assessments, however one assessment showed a left heel pressure ulcer, showing a discrepancy in the documentation. Further review of the documentation revealed a missing weekly wound care assessment note. On 43/27/25 at 4:13 p.m., the EMR was reviewed with the DON. The DON reported they understood the concerns with the documentation discrepancies and reported there should be weekly wound care documentation. The DON reported the wound was a diabetic wound per their review of the medical record, despite this Surveyor noting the documentation discrepancies, including the MDS assessment. Review of the policy, Skin Management, revised 8/14/24, revealed, It is the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. Overview: Residents with wounds and/or pressure injury and those at risk are identified, evaluated, and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes .3. Appropriate preventative measures will be implemented on residents identified at risk and the interventions are documented on the care plan . The policy did not include documentation requirements for pressure ulcers. A policy was requested for pressure ulcer care, including documentation, and was not received by survey exit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47283 This citation pertains to intake #MI00151325 Based on observation, interview, and record review, the facility failed to implement appropriate interventions timely and consistently as recommended/indicated for two (R48 and R38) of four residents reviewed for accidents resulting in the potential for further falls, elopements, and avoidable accidents. Findings include: R48 Record review revealed R48 was a long-term resident admitted to the facility on [DATE]. R48 was recently transferred to hospital on 3/19/25 for further evaluation due to altered mental status after a fall and they were readmitted back to the facility on [DATE]. R48's admitting diagnoses included dementia, anxiety disorder, heart and renal failure with history of falls. Based on the Brief Interview for Status (BIMS) assessment dated [DATE], R48 had a score of 0/15, indicative of severe cognitive impairment. Based on the Minimum Data Set (MDS) assessment dated [DATE], R48 needed moderate (staff assistance less than 50%) from bed to wheelchair; substantial (more than 50% staff assistance) for toilet transfers. An initial observation was completed on 3/25/25 at approximately 1:40 PM. R48 was sitting up in their wheelchair in their room. R48 was sitting in a regular wheelchair and it had two rear anti-tip bars. R48 was sitting inside the room at the end of the doorway in front of their bedside table. When queried how they were doing, R48 stated slow. The wheelchair did not have any other devices attached and R48 did not have any devices/bracelets on their wrists or ankles. On 3/26/25, follow up observations were completed at approximately 9:50 AM. R48 was observed sitting on their edge of their bed. R48 had a shirt on and they were attempting to pull at their pants. R48 did not have devices/bracelets on their wrists or ankles. A wheelchair was next to the bed on the right side and the wheelchair was not locked. Later that day at approximately 10:15 AM, R48 was observed sitting on the edge of their bed with the unlocked wheelchair next to the bed. At approximately 1:25 PM, R48 was observed sitting up in their wheelchair and eating lunch in their room. They did have any bracelet (as they were at risk for elopement). R48 was sitting in the same wheelchair. Later that day at approximately 4:05 PM, R48 was out in the hallway in their wheelchair near the nurses' station. R48 started moving in their wheelchair towards the elevator and multiple staff members had called R48's name trying to redirect the resident, and a staff member assisted R48 back to the nurse's station. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R48's Electronic Medical Record (EMR) revealed an order dated 8/16/24 that read, confirm placement of wanderguard on left wrist every shift. Review of R48's elopement care plan dated 8/5/24 revealed that R48 was at risk for elopement and or wandering due to multiple medical problems and interventions included apply wanderguard per order, check placement, function and expiration date per protocol. Review of R48's fall care plan revealed that R48 was at risk for falls due to their limited mobility, incontinence of bowel, cognitive deficits, history of falls poor safety awareness, and seizures. Fall prevention interventions included, anti-roll backs to wheelchair for safety initiated on 8/6/24. Anti-rollback mechanism consists of lever that directly contacts the underside of the seat and is mechanically linked to the brake arms and locked the wheelchair when a resident forgets to lock the brakes and begins to stand. Review of nursing progress notes revealed a late entry note dated 3/22/25 at 11:09 read in part, Resident was observed in room sitting up against the wall next to wheelchair and bathroom door. When asked what happened resident was unclear on what he was trying to do prior . Review of incident and accident (I&A) reports for 3/22/25 (x2) revealed that R48 had 2 falls on 3/22/25 at 0:00 and at 10:00. I&A report dated 3/22/25 at 0:00 revealed that R48 had a fall in the bathroom. The note on the I&A read, writer was told by the fell ow nurse that resident was on the floor. Writer then went resident's room and observed resident laying on the bathroom floor .Resident wasn't able to verbalize how the fall occurred. Action taken read, Writer assessed and took resident's vital signs and then put resident back in his wheelchair with the help of another nurse and continue with plan of care. The I&A report dated 3/22/25 at 10:00 read, Resident was observed sitting up against the wall in room next to bathroom door. Resident was unclear of what he was trying to do prior . Action taken section of the report read, Resident vitals were taken. Skin and neuro assessment performed and assisted back to wheelchair. NP (nurse practitioner) notified. It must be noted that R48 returned from the hospital on 3/21/25 after they were sent out related to the fall in the bathroom on 3/19/25. Further review of nursing progress note dated 3/19/25 at 14:01 revealed that R48 had an incident in the bathroom. The note read in part, Resident was observed on the bathroom floor next to toilet. R48 transferred to hospital after a fall due to change in mentation and returned back to facility on 3/21/25. Further review of progress notes revealed R48 had a fall on 2/28/25. Progress note dated 2/28/25 at 2:49 read in part, Writer observed resident in his room sitting between the bed and nightstand with his back against the wall resident stated that he was trying to get from his bed to wheelchair without assistance . Review of R48's fall care plan (post fall) dated 2/27/25 revealed interventions that included determine and address the causative factors of the fall. An intervention revised on 3/22/25 read, put the call light within reach and encourage him to use it for assistance as needed. It must be noted R48 had significant cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with LPN (Licensed Practical Nurse) X', who was assigned to care for R48 was completed on 3/26/25 at approximately 1:30 PM. LPN X reported that they had been working at the facility for approximately 1 year. They reported that that they regularly worked on the unit and they were familiar with R48. LPN X added that R48 was a fall risk and wanders. They were asked about the interventions that they had in place for R48 and they added that resident should have had a wanderguard. They just found out and they were going to put one on. LPN X stated he gets busy and needs one. LPN X reviewed R48's care plan and added that would encourage R48 to be in common areas and activities and they were doing frequent checks to keep them safe. They were queried about the anti-roll back device in the wheelchair. At approximately 1:35 PM, the nurse went in the R48's room and R48 was up in their wheelchair. LPN X showed the rear anti-tips in R48's wheelchair and thought that was the anti-roll back device. Later they stated that they were not familiar with that device and they would follow up. An interview with Unit Manager (UM) AA was completed on 3/26/25 at approximately 4:40 PM. They were queried about the supervision and implementation of fall prevention interventions as ordered and how they were monitored. UM AA reported that that they started a few months ago and 2nd floor used to be a long-term unit and they were covering for another unit. They added that they were monitoring the interventions during their rounds and it had gotten very busy and challenging recently with multiple short-term admissions every day. They were notified of the observations and concerns for R48 and they reported that they understood the concerns and they would follow up. An interview with Assistant Director of Nursing (ADON), A who was covering for the was Director of Nursing (DON) was completed on 3/27/25 at approximately 8:15 AM. ADON A was queried about the facility process to ensure that fall prevention interventions were in place as ordered. They reported that the nurse managers were monitoring during their rounds to ensure that interventions were in place. They were notified of the observations for R48 and missing wanderguard and anti-rollback device. ADON A agreed that R48 was high fall risk and needed the interventions and they were unsure why they unsure what happened and they would follow-up. They added that staff might have removed the wanderguard when R48 went out to hospital. An interview with Asst. Nursing Home Administrator (NHA) B was completed on 3/27/25 at approximately 10:05 AM. They were notified of the observations for R48 and were queried on the expectations for implementation of interventions for the fall prevention and accident prevention and they reported that they expected the team to ensure that recommended/ordered interventions were in place. They added that they understood the concerns. A facility provided document tilted Incidents and Accidents for Guests/Residents or Visitors with a revision date of 4/29/22 read in part, Incidents involving a guest/residents or visitor will be documented and reported so as to meet the regulatory requirements. The administrator and the director of nursing will be notified as outlined in this policy. Definitions: Incidents Requiring Further Investigation: Injuries of unknown origin Alleged/suspected abuse, neglect, and misappropriation of guest/resident property (continued on next page)

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	235733	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Troy	2685 West Maple Road Troy, MI 48084

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guest/resident to guest/resident contact State reportable incidents and All visitor events whether the visitor was injured or not Procedure: 1. When an incident or accident is discovered, the employee making the discovery will immediately notify his back slash her direct supervisor of the discovery period if the event requires immediate action from the administrator (guest/resident safety, family's reaction, or state regulatory requirements), administrator will be notified immediately. 2. A facility incident and accident report form are required .be completed by a licensed nurse prior to completing their shift. 3. All incidents requiring further investigation are serious incidents shall be thoroughly investigated and documented utilizing the incident and Accident Investigation form and the quality assurance interview summary 4. Return witness statements shall not be requested unless required by state law '. 38271 R38 On 3/25/25 at approximately 12:39 p.m., R38 was observed in their room, up in their bed. R38 was queried if they had any concerns regarding their care and they held up their left arm and indicated that they received a skin tear during care because the CNA (certified Nursing Assistant) did not listen to their instructions. On 3/25/25 the medical record for R38 was reviewed and revealed the following: R38 was initially admitted to the facility on [DATE] and had diagnoses including Chronic kidney disease and Spinal stenosis. R38's MDS (minimum data set) with an ARD (assessment reference date) of 1/5/25 revealed R38 needed assistance from facility staff with most of their activities of daily living. A Medical Provider progress note dated 1/23/25 revealed the following: HISTORY OF PRESENT ILLNESSES---being seen today as a f/u (follow-up). Patient states he obtained a skin tear during care. States while being cleaned and changed when being turned arm was grabbed and accidentally caused a skintear Notes: Skin tear left forearm . An encounter note dated 1/23/25 revealed the following: -Situation : nurse reports skin tear on left forearm. wound care consult initiated.-Treatment :will update rounding provider . A Physicians order dated 1/24/25 revealed the following: cleanse skin care left forearm with wound cleanser. apply generous amount of TAO (triple antibiotic ointment) cover with abd (abdominal) pad then wrap with kerlix. monitor for s/s (signs/symptoms) of infection. report any concerns to wound care nurse and NP(Nurse Practitioner)/doctor every day shift . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A incident and accident report dated 1/23/25 revealed the following: Incident Description- Nursing Description: Writer was informed during peri care resident pulled away arm from aid and skin tear on left forearm was exposed. Resident Description: Pt (patient) states aid was moving too fast while changing him and he told her not use the arm, to use the right shoulder and when she moved her hand the skin tore. Immediate Action Taken: Description: Wound was cleaned with NS (normal saline), applied TAO, 4x4 and abd and wrapped with kerlix. Pt. tolerated well .Other Info: When turning resident during pericare, use residents upper body, allow resident to inform you of best way to move him. On 3/27/25 at approximately 3:28 p.m., R38 was queried again regarding their skin tear on their left arm. R38 reported that the CNA was in a hurry and was on their personal phone with some ear buds and did not listen to them when they told them to use their shoulder. R38 reported that the CNA had moved them too fast and scratched their arm and it was bleeding from the tear. On 3/27/27 at approximately 3:50 p.m., during a conversation with the Regional Nurse consultant Z, (RNC Z), RNC Z was queried regarding the skin tear that R38 sustained during pericare on 1/23/25. RNC Z indicated that the CNA should not have grabbed R38's arm when doing bed mobility and when rolling over to the side, they should have listened to the resident instructions and used the sheet for proper repositioning while in the bed. RNC indicated if performed correctly, a skin tear should not occur during pericare.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to intake: MI00150969 Based on interview and record review facility failed to implement appropriate and consistent weight monitoring for one (R360) of six residents reviewed for nutrition resulting in the potential for unidentified weight loss and malnutrition with overall decline. Findings include: A complaint received by the State Agency revealed that R360 was admitted to the facility and did not have any appetite and was not eating well. Family had requested to transfer to the hospital because of their concern related to intake and weight loss. Additional information received via e-mail revealed that R360 was readmitted to hospital after family request and their weight was 231 pounds (lbs.) when they were readmitted to hospital; there was a 28 lbs. weight loss based on previous hospital weight (259 lbs.) prior to initial admission to the facility. The complaint also revealed that the facility failed to obtain an accurate admission weight and failed to monitor R360's weight throughout their stay even after family had brought to the facility's attention that R360 was not eating and drinking. Record review revealed that R360 was admitted to the facility for short-term skilled nursing and rehabilitation after hospitalization on [DATE]. R360's admitting diagnoses included COVID, high blood pressure, dizziness, depression, sleep apnea, and chronic lymphocytic leukemia. Based on the Minimum Data Set (MDS) assessment dated [DATE], R360 had a Brief Interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. Review of R360's Electronic Medical Record (EMR) revealed a nursing progress note dated 3/6/25 at 12:03 that read in part, Resident experienced unexpected weight loss and having decreased appetite. Nurse Practitioner (NP) at bedside. Resident reviewed and new orders with nutritional supplement. Family at bedside and per their request sent out to hospital. Family called the ambulance and left to hospital . Review of the R360's weight report revealed an initial admission weight of 276.9 lbs. dated 2/11/25 at 9:33. There were no other weight records on R360's EMR during their entire stay at the facility. It must be noted that R360's discharge weight from the hospital prior to admission to the facility was 259 lbs. An initial progress report by Registered Dietician (RD) was completed on 12/19/25 (approximately 8 days after admission). The note read, spoke with daughter during care conference about the plan of care (POC). Resident prefers to skip breakfast, typically sleeps until noon. Will usually eat 2 meals per day, but intake has been decreased. Daughter was giving ensure plus at times and will accept well. Added ensure plus with lunch and dinner . Review of R360's care plan revealed that R360 had altered nutrition and hydration status and the interventions included, obtain weekly weights x 4 weeks and then monthly if stable; observe and report to physician significant weight changes: 3% in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months . They were initiated on 2/17/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the amount eaten record from 2/25/25 to 3/6/25 revealed that R360 ate less than 25% of their food on 9 instances (meals) and less than 50% of their food on 4 instances. Further review of R360's EMR did not reveal any weekly weights or reweight for the admission weight (which had a variance of 17.9 lbs. from the discharge hospital weight). An interview with Registered Dietician (RD) G was completed on 3/26/25 at approximately 4:15 PM. During the interview they were queried about the facility's weight process for any admissions. RD G reported the facility process was to complete weekly weights for 4 weeks for all new admissions and readmission residents and they would evaluate after 4 weeks and change them to monthly weights if resident was stable. They were queried about R360's admission weight discrepancy and their weekly weights. RD G reviewed the EMR and confirmed that there were no other weights in the EMR. RD also confirmed that there was weight discrepancy with the admission weight/usual body weight and the facility did not complete a re-weight to confirm the accurate admission weight. When queried further they reported that they had used paper sheets (used as an internal document not part of the medical record) and they were inputting weights from the paper sheet to the EMR. They added that they might not have entered the weights and they needed to check the sheets. When queried even if they had the sheet it would be missing entries for multiple weeks and what was their process? They did not provide any further explanation. Later that day at approximately 5 PM, RD G came back and reported that they checked the paper sheets and the re-weight and weekly weights were requested to nursing and they were not completed. They did not provide any further explanation what was the facility process when weights for a high risk resident was not completed for multiple weeks. On 3/27/25 an interview with Assistant Director of Nursing (ADON) A who was covering for the Director of Nursing was completed. During the interview Regional Clinical Consultant (RNC) Z was also present. They were queried about the facility's weight process for any new/readmissions and they reported that the facility completed the initial weight and monitored based on the policy. They were queried about the facility process to complete a reweight and turnaround time to complete the weight. RNC Z reported that the reweights were completed within a reasonable time frame, typically the same day or next days. They were notified of the concerns with R360's weight monitoring throughout the stay. They reported that they understood the concerns and they would follow up. A facility provided document titled Weight Management with a revision date 9/22/23 read in part, residents will be monitored for significant weight changes on a regular basis. Residents are expected to maintain acceptable parameters of nutritional status, such as usual body weight and protein levels; Unless the residents clinical condition demonstrates that this is not possible period since ideal body weight charts have not yet been validated for institutionalized elderly, weight loss (or gain) is a guide for determining nutritional status. Therefore, the evaluation of significant weight gain or loss over a specific time period is an important part of the evaluation process. Anticipated Outcome: Any resident with unintended weight loss slash gain will be evaluated by interdisciplinary team and interventions will be implemented to prevent further weight loss or gain Practice Guidelines: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. All residents will have a baseline evaluation of their nutritional status within seven days of admission/readmission. The evaluation will identify risk factors for altered nutritional status. 2. Residents will be weighed upon admission slash readmission; Weekly x 4, then monthly or as indicated by physician and/or the medical status of the resident and document results in medical record. Dialysis residents' dry weight will be used. 3. Re-weights are initiated for a five-pound variance if the resident is >100 lbs. and for a three-pound variance if < than 100 lbs. If a resident's weight is >200 lbs. a re-weight will be done for a weight loss or gain of 3% or consult with the Dietary Manager or RD/designee. Re-weights will be done within 48-72 hours .

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to provide comprehensive behavioral care management for one Resident (R12) of one resident reviewed for behavior health services. Findings include: Review of R12's Minimum Data Set (MDS) assessment, dated 2/10/25, revealed R12 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, dementia, and adjustment disorder. The assessment showed R12 was independent with toileting, transfers, and walking. The sensory assessment revealed R12 was sometimes able to understand, and sometimes able to be understood, and had no vision or hearing impairment. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 3/15, which showed R12 had severe cognitive impairment. Review of the Electronic Medical Record (EMR) revealed R12 had aggressive and wandering behaviors towards residents and staff in the past month, including two resident-to-resident incidents. On 3/25/25 at 11:35 a.m., R12 was observed in their room, sleeping in their bed, with the covers pulled up partially over their head. R12's Certified Nurse Aide, (CNA) Y, was asked about their care and mood. On 3/25/25 at 11:40 a.m., CNA Y reported R12 was agitated sometimes, wandered in and out of other residents' rooms, requiring a recent psychiatric stay. CNA Y reported R12 did not eat consistently, due to their behaviors. On 3/25/25 at 12:39 p.m., R12 was observed in their bed awake with their eyes open. R12's lunch tray of uneaten food was observed on their bedside table. Certified Nurse Aide (CNA) Y asked R12 if they were hungry, and R12 stated, Yes. R12 was observed next to stand up without assistance, wearing their nightgown. R12 began pacing in the room. CNA Y pointed to their lunch tray. R12 then conveyed they did not want their lunch by gestures and speaking Arabic in rapid sentences. It was unclear if R12 did not want their lunch, or if they wanted a different lunch entree. On 3/25/25 at 12:44 p.m., CNA Y was asked how they communicated with R12, and how R12 communicated with them. CNA Y described they communicated with R12 by pointing at items in their room and seeing which items they wanted. CNA Y reported sometimes R12 wanted to say more than they could understand, and staff had tried an interpreter with limited success. CNA Y was asked if they used any other communication tool with R12 and reported they had not. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at approximately 12:30 p.m., R12 was observed in their room and had eaten their lunch. CNA Y entered their room to pick up their lunch tray from their bedside table. R12 angrily pointed at their lunch tray, and then at CNA Y. It was noted the tray had no plate, and had a food lid cover, a lidded mug of water, and an empty bag of whole-wheat chips. It appeared to the Surveyor that R12 may have wanted more tea or chips from their gestures, by pointing at these items. After CNA Y retrieved R12's lunch plate from their bathroom, R12 angrily pointed at their bed. It was noted the covers and sheet were pulled down. CNA Y thought R12 wanted to get in their bed, who indicated no with gestures, but they kept pointing at the bed. CNA Y then recognized R12 wanted assistance to make their bed. CNA Y assisted R12 to make their bed and left the corner of the bed cover draped near floor level. R12 pointed and showed CNA Y the right corner of their bedspread. CNA Y struggled to understand what R12 wanted but eventually understood R12 wanted their covers tucked in. R12 appeared pleased when their bed was correctly made, then calmed down and pointed back at their tray. CNA Y' picked up items and began guessing at what R12 wanted. There was no effort to get a communication board, an interpreter, or other communication tools, including an online translator, and none were observed in R12's room. After some guesses at what R12 wanted, CNA Y held up R12's teacup and stated, hot and R12 nodded yes. CNA Y held up R12's empty whole grain chips bag, and asked R12 if they wanted more, and R12 nodded yes, while speaking quickly in Arabic. Review of the R12's progress notes revealed the following: Review of R12's provider progress note, dated 3/22/25 at 12:00 a.m., revealed, .Unable to redirect patient and (R12) is becoming a danger to herself, staff and patients. (R12) is receiving Seroquel (an antipsychotic medication) and Trazadone (an antidepressant medication). Review of R12's progress note, dated 3/18/25 at 12:33 a.m., showed R12 was transferred to the hospital for a psychiatric stay, as they demonstrated behaviors including wandering into other resident's rooms, fighting with staff, and .(R12) was a danger to (themselves), staff and other residents. The note revealed R12's son had just passed away, and family had asked if R12 could have an interpreter. It was unclear if one was provided. Review of R12's nursing progress note, dated 3/14/25 at 5:45 p.m., revealed a resident-to-resident incident, when R12 became aggressive with another facility resident and their family, and yelled at them in Arabic (language). When staff asked them to leave the room, R12 struck staff in the chest. Per the note, the police were called and R12 was escorted out of the facility and petitioned for a psychiatric stay. Review of R12's nursing progress note dated 3/14/25 at 12:18 a.m. revealed R12 had become more combative towards staff and other residents . and was difficult to redirect due to language barrier . The note further revealed (R12) will not stay out of other residents' rooms ., prior to the resident-to-resident incident on 3/14/25. Nurse noted, Concern not English speaking from EMR (Electronic Medical Record), will explore further . Review of R12's nursing progress note, dated 3/13/25 at 6:51 a.m., revealed R12 had been wondering (sic) into residents' rooms and throughout 3rd floor; (R12) is unable to be redirected by staff at times . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R12's progress notes in the past month (through 3/25/25 at 4:30 p.m.) showed no social work visits including supportive visits, staff education, or interventions implemented to intervene, follow-up for resident-to-residents visits, attempts at facilitating improved communication, or support for the recent death of R12's son, given R12's ongoing aggressive and wandering behaviors. On 3/26/26 at 4:39 p.m., Social Worker U was asked how they were addressing R12's ongoing and increasingly aggressive behaviors, and how they communicated with R12, given observations of R12 attempting to communicate their basic needs, their agitation, and the resident-to-resident incidences. SW U reported they did not know this resident personally and how to best communicate with them, and neither did the other social worker in the building, as R12's regular social worker was out on a medical leave. SW U reported they were trying to send referrals for R12 to other facilities with a larger population of Arabic people and had been unsuccessful at alternate placement, possibly given R12's behaviors. SW U was asked why there were no social services visits recorded after the resident-to-resident incidents, and on the dates when R12 had aggressive and dangerous behaviors. SW U reviewed the EMR with this Surveyor, and acknowledged they would have expected to see social work notes and visits, given R12's ongoing and escalating aggressive behaviors. SW U stated social services staff should have provided supportive visits and follow up, and this should have been documented in the EMR. Further review of the EMR with SW U revealed the last behavioral care provider visit was on 3/05/25. SW U acknowledged there should have been psychosocial support and follow-up, as R12 may have benefited from medication adjustment, or other interventions. SW U was asked how if R12's BIMS assessment would have been administered in Arabic, given a score of 3/15, which showed severe cognitive impairment, and this Surveyor observed R12 functionally communicating some basic needs with CNA Y. SW U reported they were unaware of how the BIMS was administered, or the facility process for administering the BIMS to Arabic-speaking residents, and could not determine if it was administered in English or Arabic. Regarding the lack of social services interventions, SW U reported the facility census had been increasing rapidly, with four to five new residents admitting every day, and the facility had an open position for a social worker. SW U was asked if this would impact the residents and respectfully declined to answer. SW U reported they were running ragged, and their staff were doing their best, given the increasing census, and said they sometimes worked 12-hour days. SW U reported typically a resident with these types of behaviors would have had their medications thoroughly reviewed and adjusted, seen a behavioral care provider, had social work supportive visits and follow-up, and functional communication would have been addressed by social services. SW U reported R12 would have likely benefited from music activities. Review of R12's social services reassessment, by SW U, dated 3/25/25, showed R12 in question 4: Has the resident/guest experienced any change in their mood/behavior status since the last assessment? The answer was marked No. The assessment noted R12 had recently lost their adult son who passed away. Interventions showed, Distract with music and provide reassurance. R12's ongoing behaviors were not addressed in this reassessment. Review of R12 activity logs for the past 30 days, accessed 3/26/25, showed R12 did not participate in music activities. Observations of R12 by this Surveyor on 3/25/25, 3/26/25 and 3/27/25 revealed no music or music player in their room, and no music playing, despite agitation on 3/26/25. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at approximately 1:42 p.m., the facility Speech Language Pathologist, SLP BB, was asked about R12's functional communication, and if R12 had been seen by speech therapy services. SLP BB reported R12 had never been on their caseload since their admission or referred for speech therapy since their admission. SLP BB said they would screen R12, and their potential to benefit from functional communication tools to improve their communication with staff. On 3/27/25 at 2:07 p.m., SLP BB shared they had screened R12 for functional communication. SLP BB indicated R12 had used the Arabic communication book on the unit, and showed the Surveyor the first page, labeled Basics. SLP BB revealed R12 had demonstrated the ability to communicate three basic needs from a brief screening, which were hairbrush, toilet, and cold drink, and had demonstrated the ability to read the Arabic phrases, they believed. SLP BB showed the Surveyor the communications basics page had 20 pictures, with words in English and Arabic at the bottom. SLP BB reported R12 would benefit from a modified page which had 12 pictures at the most, with larger Arabic print. SLP BB explained the interpreter had been assessing R12 when they were present, and they learned R12 was speaking two different dialects of Arabic, and sometimes combined Arabic with English speech, which was a common presentation in bilingual persons with cognitive impairment. SLP BB conveyed staff should have been using the Arabic communication book to assist R12 in communicating at least basic needs, which was not found documented in the EMR. SLP BB clarified they understood the BIMS score would be reflective of how it was administered, in which language, and this may impact the scoring. SLP BB stated part of their job would have been to work with the facility on building culturally sensitive communication policies, and they planned to do this going forward. SLP BB described the presentation of the current Arabic book communication boards as inefficient, and noted improving the functionality of the communication book would be a matter of templating and reformatting for improved communication for Arabic-speaking residents. This Surveyor noted on the Basics page, there was a picture for hot beverages, which R12 had been observed trying to communicate to CNA Y on 3/26/25. Review of a Social Services progress note dated 3/26/25 at 5:30 p.m., after meeting with this Surveyor, revealed, SW was made aware that (R12's) son/guardian had been killed recently in a car accident. SW reached out to (R12's family) .to enquire about facility assisting with the process of amending guardianship . SW to also ensure (Behavioral Care Provider) to further evaluate for symptoms of grief and loss and treat as indicated. SW to continue to monitor. Review of a Social Services progress note, dated 3/27/25 at 2:40 p.m., revealed, (R12) was seen by (Behavioral care provider) today, notes to follow. Review of R12's speech therapy note, dated 3/27/25 at 2:51 p.m., after meeting with the Surveyor, revealed, (R12) approached by ST (Speech Therapist) as part of screening or communication status. (R12) noted to be able to read Arabic script on communication boards and indicate understanding.ST will provide staff with refined Arabic communication board to improve pt (patient) communication with caregivers. (continued on next page)

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Regency at Troy	2685 West Maple Road Troy, MI 48084

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Social Services Program, revised 3/26/25, revealed, The facility will provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Residents will be encouraged to attain or maintain mental and psychosocial health .1. Each facility will meet the psychosocial needs of each resident .3. The social services department will assist with such needs as listed below e. Making referrals and obtaining needed services from outside entities .h. Providing or arranging for identified psychosocial counseling services .m. Assisting or arranging for a resident's communication of needs through resident's primary method of communication or in a language that the resident understands .n. Meeting the needs of residents who are grieving from losses, coping with stressful events or trauma experiences .Situations in which the facility should provide social services or obtain needed social services from outside entities include but are not limited to the following: a. Lack of an effective family or community support of legal representative. b. Expressions or indications of distress .f. Adjustment difficulties .Documentation: .5 BIMS .are completed to determine mental status . A policy was requested on 3/27/25 related to Behavioral Care Management and was not received by survey exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure medications, including medications used for treatments, were appropriately stored and in a safe manner for four residents (R45, R46, R81 and R7) of four residents reviewed for safe storage. Findings include: Review of a facility policy titled, Medication/Treatment Cart Use revised 8/15/23 read in part, .The nursing staff uses the medication/treatment cart to systematically distribute physician ordered medications to residents . The medication/treatment cart and its storage bins are kept locked until the specified time of medication/treatment administration . R46 On 3/27/25 at 11:23 PM, upon entering R46's room with Licensed Practical Nurse (LPN) C, who served as the Wound Care Nurse, a bottle of Half Strength Dakin Solution (a dilute sodium hypocholorite solution commonly known as bleach) was observed on the three drawer cabinet next to R46's bed. The bottle was labeled with an open date of 3/14/25. LPN C was asked about the bottle of Dakin Solution. LPN C explained Dakin Solution should not be left in a resident room, it should always be locked in the treatment cart. Review of the clinical record revealed R46 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: heart disease, peripheral vascular disease and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R46 had severely impaired cognition. R81 On 3/27/25 at 11:55 AM, upon entering R81's room with LPN C, a bottle of Wound Cleanser was observed on the dresser across from R81's bed. LPN C was asked about the Wound Cleanser in R81 ' s bed. LPN C explained the Wound Cleanser should also be locked in the treatment cart. Review of the clinical record revealed R81 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: stroke, dementia and diabetes. According to the MDS assessment dated [DATE], R81 had severely impaired cognition. On 3/27/25 at 2:30 PM, the Assistant Director of Nursing (ADON), who was the acting Director of Nursing, was interviewed and asked about the Dakin Solution if R46 ' s room and the Wound Cleanser in R81 ' s room. The ADON explained no medication should be left in the residents ' rooms, they should be locked in the medication and/or treatment carts. 49083 Resident #7 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 11:22 AM, during an interview with R7, the following medications were observed on their bedside table: Voltaren Topical(Diclofenac, a nonsteroidal ant-inflammatory/NSAID to reduce pain), Triad Paste (zinc-oxide based paste used in wounds to facilitate debridement), saline nasal spray (sterile solution of salt and water used to moisturize, lubricate, and flush nasal passages). On 3/27/25 at 2:40 PM, R7 was observed in their room; while conversing, an observation of their bedside table revealed the same medications as observed on 3/25/25 (Volatren, Triad Paste and Nasal Spray). On 3/27/25 at 4:41 PM, an interview with R7's assigned nurse was conducted. Licensed Practical Nurse (LPN) J was questioned why medications were at the bedside, and LPN J replied they were not aware medications were at the bedside. On 3/27/25, Record review revealed there were no orders for R7 to self-administer medications. Resident #45 On 3/27/25 at 9:45 AM, LPN H was observed providing wound care to R45's abdomen with a spray bottle of wound cleanser and gauze. After cleansing, the bottle of wound cleanser was observed being left at the bedside. On 3/27/25 at 2:45 PM, an observation revealed the bottle of wound cleanser remained at the bedside of R45. On 3/27/25, a review of the Policy tiled; Medication Administration, dated 10/23 documented: .Do not leave medications with the resident to self-administer unless the resident is approved for self-administration of the medication .

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review the facility failed to ensure a laboratory diagnostic (lab) was completed in a timely manner per the Physician's order for one resident (R13) of one residents reviewed for laboratory diagnostics. Findings include: On 03/25/25 the medical record for R13 was reviewed and revealed the following: R13 was initially admitted to the facility on [DATE] and had diagnoses including Heart failure and Chronic kidney disease. A review of R13's MDS (minimum data set) with an ARD (assessment reference date) of 2/23/25 revealed R13 needed assistance from facility staff with most of their activities of daily living. A Physicians order dated 2/25/25 revealed the following: STAT (immediate) CBC (complete blood count) W DIFF (with differential) CMP (comprehensive metabolic panel) Further review of the medical record did not reveal any CBC results from the lab order dated 2/25/25. On 3/27/25 at approximately 9:20 a.m., Nurse manager AA (NM AA) was queried regarding the lab order for the CBC with Diff results that had been ordered on 2/25/25. NM AA was observed reviewing R13's record and the laboratory portal and indicated that they saw the results for the CMP but nothing for the CBC with differential and indicated that was probably an oversight with the lab requisition. NM AA was queried if they could provide any requisitions made by the Nurse for the CBC and they reported there were none done. NM AA was informed that if they found the results of the CBC they could provide it before the end of the survey. The CBC with differential lab results for 2/25/25 were not provided by the end of the survey.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview and record review, the facility failed to provide alternate menus and alternate meal choices for one Resident (R312) of one resident reviewed for menus. Findings include: Review of the R312's Minimum Data Set (MDS) assessment, dated 3/16/25, revealed R312 was admitted to the facility on [DATE], with diagnoses including heart failure, kidney failure, femur fracture, and malnutrition. R312 was independent with eating, was 68 inches tall, and weighed 176 pounds. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which showed R312 was cognitively intact. On 3/25/25 at 12:03 p.m., R312 was observed lying in their hospital bed, with their Family Member, FM II , seated in their room. FM II reported R312 did not like the lunch entree so they went to a local restaurant and brought them a meal. FM II stated they had asked facility staff for an alternative menu several times, and none was provided, which R312 confirmed. R312 stated, None of the food tastes good. They (staff) try to make the meat like a meatloaf or roast, and it does not taste like it. FM II explained when R312 received a hamburger, R312 kept getting a tomato on it, which was not allowed on their renal diet. Certified Nurse Aide (CNA) EE arrived, and FM II stated they would like an alternative menu, and asked CNA EE to bring them one. CNA EE reported they would return with an alternate menu and left the room. On 3/25/25 at 12:10 p.m., CNA EE was asked about the menus and if residents had an option for an alternative meal choice. CNA EE explained there had been some turnover of staff in the kitchen management, and reported the facility was recently offering alternatives. CNA EE reported the activities staff in the past had taken resident food orders, and were not currently, as a staff member had left their position. On 3/26/25 at 2:06 p.m., R312 was observed in their bed, with FM II in R312's room, with a second family member. R312 was observed eating a hamburger FM II brought them from a local restaurant. On 3/26/25at 2:10 p.m., R312 and FM II reported they still wanted an alternative menu and had never received one from CNA EE or any staff yesterday. FM II checked in the facility document folders for an alternate menu with none found, and none was observed in R312's room. R312 and FM II reported they both felt frustrated with the food quality and not having an alternative menu with other choices. Both stated they heard the facility offered an alternative menu, but said they had never seen the menu, despite asking multiple staff for one. FM II reported they were bringing R312 outside food every day, as they did not want R312 to lose weight. FM II reported R312 needed good nutrition for participating in therapy and recovering from their recent fracture. On 3/27/25 at 2:36 p.m., Dietary Aide, Staff GG, was observed in the main floor dining room, setting up tables. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 2:38 p.m., Staff GG was asked for a copy of an alternative food menu, with other meal options for residents who did not want the food entree. Staff GG reported they had only worked at the facility about two months, and stated, I don't know. I don't think we have one (an alternative menu). I have never seen one. Staff GG stated the cook would know, and asked [NAME] HH to speak with the Surveyor. [NAME] HH came to the kitchen door, stated they had to leave for the day, and left. On 3/27/25 at 3:04 p.m., the wall outside the main dining room was observed. The menus for the day were observed, and blank plastic sleeve to the left of them was labeled Daily Options. There was no alternative menu, or any menu posted there. On 3/27/25 at 3:08 p.m., Registered Dietician (RD) G reported they heard there were questions about the alternative menu, RD G stated Staff GG may not have understood what an alternative menu was. RD G said they called the menu with alternates, The Bistro Menu, and stated it should have been posted with the menus outside the dining room. RD G explained the alternative menus were posted at the nurse's stations but were not in each residents' rooms. This Surveyor explained R312's concerns and not having an alternative menu since they ate in their room. RD E stated they understood the concern and would be sure going forward to include them in a resident 'welcome bag', or similar place so every resident had a copy. This Surveyor asked for a copy of the alternative food menu, or Bistro menu. On 3/27/25 at 3:20 p.m., this Surveyor viewed a color copy handout of an alternate menu titled, Bistro, which included at least four alternate food options for each meal. It appeared it would accommodate the food variety needs of most residents. Review of the policy, Meal Alternates, revised 1/09/25, revealed, Policy: It is the policy of this facility to provide an alternate of similar value when a resident does not eat the majority of a meal. Procedure: 1. Alternate food items will be planned into the menu cycles. These alternates will be prepared by the Nutritional Services staff. 2. The alternate will be posted along with the main scheduled meal .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation, interview, and record review, the facility failed to provide an attractive palatable pureed meal to one resident (R45) of one resident reviewed for meal service, resulting in verbalized complaints and dissatisfaction with meal service and potential for weight loss. Findings include: Clinical record review revealed R45 was admitted to the facility on [DATE] with a history of recurrent cerebral vascular accidents (stroke), resulting in left sided weakness, and dysphagia (difficulty swallowing) and required a Percutaneous Endoscopic Gastrostomy (PEG) tube (a surgically placed tube into the stomach to provide nutrition). R45 had vascular dementia, and the Brief Interview of Mental Status (BIMS) assessed on 1/25/25 scored 11/15 indicating moderate cognitive impairment. Review of the dietary progress note dated 11/5/24 revealed R45 had received pureed pleasure trays (pleasure feeding offers comfort through the enjoyment of food) in addition to their ordered nutrition via PEG. R45 was identified at risk for weight loss. On 3/26/25 at 8:58 AM, an observation of the breakfast tray contained two semi formed [NAME] of tan colored pureed, unrecognizable food. A review of the meal ticket was conducted but did not indicate what foods were on the plate, it only indicated that R45 was ordered a regular Level 1 pureed diet, Standing orders: 6 Fl (fluid) oz (ounce) Coffee, 6 oz Juice. On 3/27/25 at 12:15 PM, during an interview with Registered Dietician G (RD G) the breakfast meal ticket from breakfast for R45 was shown and per RD G food prepared is not listed on the meal tickets and residents and or family need to refer to the daily menu to see what foods are being offered. On 3/27/25 at 12:26 PM, RD G was observed in the room with R45's son who further validated frustration with the presentation and unrecognizable food for their parent. The family member further remarked one time there was a pile of green slimy stuff that they would not even try. The family questioned why the food are not identified on the tickets and RD G replied they are the same foods on the daily menu and pureed meal descriptions are located on the daily/calendar menu. Per family, and observation, they had no knowledge of this and indicated there was never a menu provided to them. When queried about why the lunch tickets did not list the foods on the plate, Regional Dietician 'F' explained that it was not the facility's policy to list the foods on the ticket.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: On 3/25/22 at 9:10 AM, during an initial observation of the kitchen, 4 whole, foil-wrapped frozen turkey breasts were observed in the sink basin. The faucet was running with a thin stream of running water flowing over 1 of the frozen turkey breasts. On 3/25/25 at 12:00 PM, all 4 turkey breasts were still in the sink basin, this time with no running water. When queried at that time, Dietary Staff CC stated he was getting ready to cook the turkey, which would be served on the following day. According to the 2017 FDA Food Code section 3-501.13 Thawing, Except as specified in (D) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be thawed: 1.(A) Under refrigeration that maintains the FOOD temperature at 5 C (41 F) or less; or 2. (B) Completely submerged under running water: 1. (1) At a water temperature of 21 C (70 F) or below, 2. (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and 3. (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5 C (41 F), or 4. (4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under 3-401.11(A) or (B) to be above 5 C (41 F), for more than 4 hours including: 1. (a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking, or 2. (b) The time it takes under refrigeration to lower the FOOD temperature to 5 C (41 F);. On 3/25/25 at 2:30 PM, Dietary Staff CC was queried about the 4 turkey breasts that had been observed in the sink basin. Dietary Staff CC stated the turkey breasts were in the oven, and that he would take them out in about an hour, and cool them (whole, un-sliced) in the walk-in cooler. Dietary Staff CC stated they would be sliced tomorrow and re-heated, to be served at one of the meals. When asked if they utilized cooling logs, Dietary Staff CC stated not to his knowledge. According to the 2017 FDA Food Code section 3-501.14 Cooling, 1. (A) Cooked POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be cooled: 1. (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and 2. (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. According to the 2017 FDA Food Code section 3-501.15 Cooling Methods, (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3) Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/25/25 at 11:50 AM, the food prep counter next to the steam table was observed with dried on food spills. In addition, the counter where the microwave was stored, was observed to be soiled with crumbs and food spills, and there were clean coffee mugs and glasses stored directly on the dirty counter. Also, the counter top where the coffee maker was stored was observed to be soiled with food spills, and there were clean bowls stored on the soiled counter. According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. According to the 2017 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, (A) Except as specified in (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; On 3/25/25 at 12:10 PM, there were no red sanitizer buckets set up in the kitchen. In one of the food prep sinks, there were 3 wiping cloths lying directly inside the dry sink basin. When queried, Dietary Staff CC stated they only had 1 red bucket (which was empty and located near the 3 compartment sink). Dietary Staff CC stated he would order some more. Several minutes later, Dietary Staff CC stated he had found some more red buckets. According to the 2017 FDA Food Code, Section 3-304.14 Wiping Cloths, Use Limitation, .(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114;

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview, and record review facility failed perform appropriate hand hygiene during medication administration (R80, R35, R59), and wear appropriate Personal Protective Equipment (PPE) while providing service/care to resident(s) (R45, and R365) who were on contact precautions and enhanced barrier precautions respectively, for five of five residents reviewed for infection prevention/control practices resulting in the potential for cross-contamination with likelihood for spread of infection. Findings include: R365 R365 was admitted to the facility for skilled nursing and rehabilitation on 3/18/25. R365's admitting diagnoses included hemiplegia (stroke), urinary tract infection, pneumonia and Clostridioides difficile (C. Diff) infection of the colon (Bacterial infection in the longest part of the large intestine. Symptoms can range from diarrhea to life-threatening damage to the colon) and dementia. During an initial observation completed on 3/26/25 at approximately 8:15 AM. R365's door had a signage that revealed that they were on contact precautions. There was a PPE cart with supplies outside of the room. At approximately 8:20 AM, a Certified Nurse Assistant (CNA) DD was observed walking into R365's room with their breakfast tray. CNA DD did not don any PPE (gown, gloves) prior to entering the room. CNA DD stayed in the room approximately 3 minutes. An interview with CNA DD was completed after they had exited R365's room. They were queried about their facility process for resident's who were on contact precautions. CNA DD reported that they did not perform any care for R365. They added that they had just dropped off the breakfast tray and had set it up on the table for the resident and they were still sleeping. They added that they would wear appropriate PPE during care and did not need to wear any PPE for this encounter. Review of R365's Electronic Medical Record (EMR) revealed a physician order dated 3/18/25 that read, contact (transmission based precautions) related to C. Diff., pneumonia. Review of R365's care plan did not reveal any care plan for contact precautions. A nursing progress notes dated 3/23/25 at 3:48 read in part, Resident continues on contact precautions and oral antibiotic therapy for C. Diff. and pneumonia diagnosis . An interview with License Practical Nurse (LPN) DD (who was assigned to care for R365 during that shift) was completed on 3/27/25 at approximately 8:45 AM. They were queried about the facility PPE process for residents who were on contact precautions. LPN DD reported staff should use appropriate PPE prior to entering the room even if they did not provide care. (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	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Troy	2685 West Maple Road Troy, MI 48084

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Assistant Director of Nursing (ADON) A who was covering for the Director of Nursing (DON) was completed on 3/27/25 at approximately 8:30 AM. They were asked to clarify the order that read contact precautions for pneumonia and C. Diff. They reported that R365 was on droplet prior and they had discontinued and were currently on contact precautions for C. Diff. ADON A was queried about their staff expectations on PPE for residents who were on contact precautions. They reported that residents who were on contact precautions were set up with their own PPE supply cart and staff were not to share that with any other residents and staff were expected to use a gown and gloves anytime they entered the room. The DON and Regional Clinical Consultant (RCC) Z' were also notified of the concern on 3/27/25 at approximately 11:40 AM. They were notified of the observations for R365 and they reported that they understood the concern and would follow-up. A facility provided document titled, Infection Prevention Program Overview read in part, The facility establishes a program under which it: Investigates, identifies, prevents, reports and controls infections and communicable diseases for all residents, staff, contractors, consultants, volunteers, visitors and others who provided care and services to the residents on behalf of the facility, and students in the facilities nurse aid training program or from affiliated academic institutions; 1. Is based upon facility assessment 2. Follows accepted national standards Decides what procedures such as isolation, should be applied to an individual resident. Maintains a record of incidents and corrective actions related to infections. Preventing Spread of Infection: When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident the facility must prohibit employees with the communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. The facility must require staff to clean their hands after each direct resident contact using the most appropriate hand hygiene professional practices . 49083 Resident #45 Clinical record review revealed R45 was admitted to the facility on [DATE] with a history of recurrent cerebral vascular accidents (stroke), resulting in left sided weakness, dysphagia (difficulty swallowing) and required a Percutaneous Endoscopic Gastrostomy (PEG) Tube (a surgically placed tube into the stomach to provide nutrition). R45 had vascular dementia, and the Brief Interview of Mental Status (BIMS) assessed on 1/25/25 scored 11/15 indicating moderate cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/25 at 9:43 AM, upon entering R45's room, Enhanced Barrier Protection (EBP) signage was observed posted on the door and Personal Protective Equipment (PPE) supplies were available. R45 had returned from the hospital for a concern with their PEG tube and Certified Nurse Assistant (CNA) I was observed not donning the required PPE (did not don the gown). CNA I was observed taking R45's vitals, removing multiple thin white blankets, lifting up the hospital gown exposing the PEG tube, and commented while touching the tube, oh you got a new pretty one. On 3/27/25 at 9:45 AM, Licensed Practical Nurse (LPN) H was observed entering the room not donning the required PPE (did not don the gown) and began performing a skin assessment with CNA I , lifting R45's legs, removing heel protector boots, touching the feet, and rubbing their legs, removal of the right leg shin telemetry sticker, and bulked up linens both on top and underneath R45. Both LPN H and CNA I were observed rolling R45 to their left side, removed a blue ripped brief, and performed a skin assessment on the sacral area. Further observation of the assessment included LPN H removed the split gauze covering the PEG insertion site which was noted with moderate amounts of dried blood on the abdomen. LPN H proceeded to cleanse the surrounding area with a spray bottle of wound cleanser and gauze around the PEG insertion site without proper PPE attire. Medication Administration On 3/26/25 at 9:46 AM, an observation of medication administration was conducted with Licensed Practical Nurse (LPN) E for R35. After administrating the medication, LPN E was observed not performing hand hygiene and commenced medication preparation for R80. On 3/26/25 at 9:59 AM, LPN E was observed not performing hand hygiene prior to medication administration to R80. On 3/26/25 at 10:11 AM, LPN E commented that the power for the computer on the cart was low and required moving the cart down the hall and closer to the electrical outlet. LPN E took the power cord located behind the cart and plugged into the wall. LPN E proceeded to prepare medications for administration for R59 without hand hygiene. On 3/26/25 at 10:29 AM, LPN E was questioned about their hand hygiene performance and acknowledged that they were not consistent with hand hygiene in between medication administration for the residents observed. On 3/26/25 at 10:44 AM, an observation of medication administration was conducted with LPN F and was observed with long squared French manicured V-shape painted tipped nails. LPN F had prepped medications for R35 with no hand hygiene. R35 was administered their medications and LPN E proceeded moving the medication cart down another hall without performing hand hygiene. On 3/26/25 at 11:02 AM, LPN E was questioned about their hand hygiene performance and acknowledged hand hygiene was not done. LPN E responded they meant to ask another staff member if they had hand sanitizer they could place on top of their medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/25 at 4:45 PM, the Assistant Director of Nursing (ADON) was informed of the observations and acknowledged hand hygiene must be performed before and after medication administration. When asked about the facilities policy for staff and having long nails, the ADON replied this is on their Personal Radar and will be addressing both observations. According to the facility policy title, Medication Administration dated 10/2023 documented: .Follow Infection Control practices .Perform hand hygiene prior to medication preparation for each medication pass. Perform hand hygiene after direct resident contact .