| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **624030** | A. BUILDING _____ B. WING _____ | **5/29/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **REGENCY AT FREMONT** | **4554 W 48TH ST FREMONT, MI 49412** |

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| F0000 SS= | INITIAL COMMENTS<br><br>Regency at Fremont was surveyed for a revisit survey from 5/28/25-5/29/25.<br><br>Census: 84 | F0000 | | |
| F0658 SS= E | Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to follow professional standards of nursing practice for medication and treatment administration for four of seven residents (Residents #301, #309, #305, and #300) as well as residents residing on the Maple and Oak Units, reviewed for the provision of nursing services.<br><br>Findings:<br><br>Resident #301 (R301)<br><br>Review of an "Admission Record" revealed R301 was an 88-year-old female, admitted to the facility on 11/27/23.<br><br>Review of R301's "Order Summary" dated 5/19/25 revealed, "LORazepam (Ativan) Concentrate 2 MG/ML Give 0.25 ml by mouth two times a day" related to her diagnosis of adjustment disorder with mixed anxiety and depressed mood. | F0658 | | 5/13/2025 |

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

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

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| | Review of R301's "Controlled Drug Record" revealed that on 5/20/25, 5/21/25, 5/22/25,5/23/25, and 5/24/25 only one dose of Ativan was documented as dispensed.<br><br>Review of R301's May "Medication Administration Record" revealed that on 5/20/25, 5/21/25, 5/22/25,5/23/25, and 5/24/25 2 doses of Ativan were documented as administered.<br><br>During an interview on 5/29/25 at 8:00 AM, Nursing Home Administrator (NHA) confirmed the noncompliance with controlled medication administration and had begun education with the licensed nurses.<br><br>Resident #309 (R309)<br><br>Review of an "Admission Record" revealed R309 was an 82-year-old female, admitted to the facility on 9/7/22.<br><br>Review of R309's "Order Summary" dated 12/2/23 revealed, "Metoprolol Succinate ER Oral Tablet Extended<br><br>Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day HOLD for SBP <120 (systolic blood pressure [top number] less than 120) and/or pulse <60 (less than 60)."<br><br>Review of R309's "Blood Pressure and Pulse Summary" and "Medication Administration Record" revealed:<br><br>*On 5/13/25 the blood pressure and pulse obtained on 5/12/25 was utilized and an updated blood pressure and pulse were not assessed.<br><br>*On 5/19/25 R309's systolic blood pressure was less than 120 and the metoprolol was administered. | | | |

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| | *On 5/21/25 R309's pulse was less than 60 and the metoprolol was administered.<br><br>During an interview on 5/29/25 at 9:25 AM, NHA confirmed the above metoprolol administration errors and reported that the licensed nurses were expected to follow physician ordered parameters.<br><br>Resident #305 (R305)<br><br>Review of an "Admission Record" revealed R305 was a 68-year-old female, admitted to the facility on 5/21/25.<br><br>Review of R305's "Order Summary" dated 5/21/25 revealed, "Weigh Daily. Notify physician if weight >2.5 lbs/24 hours OR >5 lbs/week every day shift for CHF (congestive heart failure)."<br><br>Review of R305's "Treatment Administration Record (TAR)" revealed that there was no weight documented on 5/26/25 or 5/28/25. The weight obtained on 5/25/25 was also documented as the weight on 5/27/25.<br><br>Review of R305's "Weight Summary" revealed that on 5/25/25 R301's weight was 107.9 pounds. On 5/26/25 R301's weight was 111.2 pounds. On 5/27/25 R301's weight was 111.5 pounds. Confirming a greater than 2.5-pound weight gain in 24 hours.<br><br>Review of R305's "Electronic Medical Record" revealed no documentation that the provider was notified of the weight gain.<br><br>During an interview on 5/29/25 at 9:25 AM, NHA confirmed the inaccurate weight documentation in R301's TAR and reported previous weights were not to be utilized as a | | | |

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| | current weight. NHA confirmed there was no documentation to support that the licensed nurses notified the provider of the greater than 2.5-pound weight gain.<br><br>Resident #300 (R300)<br><br>Review of an "Admission Record" revealed R300 was an 84 year old female, last admitted to the facility on 02/22/25, with pertinent diagnoses of heart failure, history of colon cancer, and high blood pressure.<br><br>During an observation on 05/28/25 at 9:42 AM, R300 sat upright in bed with her eyes open watching TV. R300 had a fentanyl patch adhered to her left upper arm. R300 stated that nursing change the patch every 3 days. The fentanyl patch was dated 5-24.<br><br>Review of an electronic medication administration record (Emar) dated May 2025, reflected R300 had an order for fentanyl transdermal patch 75 micrograms/ hour one patch every 3 days. The Emar reflected that the last fentanyl patch was placed on 05/24/25. Per the physician order and the Emar, the fentanyl patch was scheduled to have been changed on 05/27/25.<br><br>During the same above observation, a small plastic medication cup that contained approximately 10 pills sat on R300's overbed table as well as two white capsules that sat directly on the overbed table. R300 stated that the two white capsules were acetaminophen and that she does not like to take morning medications until she has eaten breakfast.<br><br>Review of the electronic health record (EHR) for R300, revealed that an assessment to determine if R300 was able to safely administer her own medications to herself had not been completed. | | | |

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| | During an interview on 05/28/25 at 10:30 AM, Licensed Practical Nurse (LPN) "B" indicated that the standard of practice was to watch a resident take their medications when administered.<br><br>Review of the Oak Unit "Treatment Administration Record" revealed that during the night shift on 5/24/25, 4 resident treatments were not documented as completed. During the night shift on 5/25/25, 8 resident treatments were not documented as completed<br><br>Review of the Maple Unit "Treatment Administration Record" revealed that during the day shift on 5/28/25, 7 resident treatments were not documented as completed.<br><br>During an interview on 5/29/25 at 9:55 AM, NHA and Director of Nursing (DON) confirmed the Oak and Maple Unit treatments had not been documented as completed. DON and NHA reported that the licensed nurses were expected to complete their shift documentation prior to exiting the building and were expected to follow provider treatments. DON and NHA reported licensed nurses were expected to provide care and treatment following professional standards of practice and there would be a mandatory educational meeting for the licensed nurses regarding medication and treatment administration and documentation.<br><br>Review of Fundamentals of Nursing (Potter and Perry) 11th edition revealed, "(Nurses) are also responsible for documenting any preassessment data required with certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. After administering a medication, immediately document which medication was given on a | | | |

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| | patient's MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care." Potter, Patricia A.; Perry, Anne G.; Stockert, Patricia A.; Hall, Amy. Fundamentals of Nursing - E-Book (pp. 643-644). Elsevier Health Sciences. Kindle Edition.<br><br>Review of Fundamentals of Nursing (Potter and Perry) 11th edition revealed, "Responsibilities of medication administration include knowing medication therapeutics, assessing a patient before administration, calculating doses, administering medications using the seven rights, monitoring and evaluating medication effects, and assessing a patient's ability to self-administer medications." Potter, Patricia A.; Perry, Anne G.; Stockert, Patricia A.; Hall, Amy. Fundamentals of Nursing - E-Book (p. 705). Elsevier Health Sciences. Kindle Edition. | | | |