STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824500	A. BUILDING _____ B. WING _____	**7/7/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY, A VILLA CENTER	**12575 S TELEGRAPH RD TAYLOR, MI 48180**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Regency, A Villa Center was surveyed for an Abbreviated survey on 7/7/25. Intake: MI00153114. Census: 209	F0000		
F0627 SS= D	Inappropriate Discharge §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the	F0627		

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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	appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting			

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	residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as			

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	applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but			

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	is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: This citation pertains to MI00153114.			

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	Based upon interview and record review, the facility failed to ensure transfer documentation was in place for one resident (R101) reviewed for transfer, resulting in the lack of information regarding resident's health status, safety, and transfer arrangement and destination upon transfer from the facility. Findings include: A review of the clinical record documented R101 was originally admitted to the facility on 4/9/25 and readmitted on 5/2/25. R101's medical diagnoses included anxiety disorder, mood disorder, unspecified psychosis, and unspecified dementia with other behavioral disturbance. A Minimum Data Set assessment dated 5/8/25 documented moderate cognitive impairment, impairment on one side of the lower extremity, and the use of a wheelchair for mobility. Census documentation in the EHR (electronic health record) revealed a stop billing date of 5/15/25 which indicated R101 no longer resided in the facility. Beginning on 7/7/25 at 2:58 PM, the Director of Nursing (DON) was interviewed regarding R101's status. The DON provided an incident report for R101 dated 5/15/25 that documented in part the following, "Resident repeatedly became agitated with staff regarding a pair of overalls he insists that were lost at the facility. Resident did not come to the facility with any belongings, staff tried to redirect resident over 5x regarding overalls and calm him down, resident was given all of his prn (as needed) medications and continued to become increasingly agitated despite being given prn meds...resident went down the hallway and staff thought resident was going back to his room, instead of going to his room, resident went down to the end of the hallway and kicked in the stair well door, staff heard the door be hit			

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	and went running down the hallway, down the stairs towards the resident, resident then dragged his wheelchair and pushed his wheelchair down the stairs, staff went down the stairs towards the resident and attempted to get him to stop going down the stairs. Resident began kicking, screaming, and spitting at staff. Resident then got down to the 3rd floor and got the door opened and began charging at the 3rd floor unit manager. Three staff members were able to get the resident calm enough to get him into the elevator and back to the 5th floor. Once back on the 5th floor the resident continued to kick staff members and spit on them and repeatedly threatened to punch and kill the staff members trying to redirect him. Writer was able to get a verbal (order) to send the resident to the hospital via 911 on a psychiatric petition. Resident was given a one time order for 5 mg/1 ml of Haloperidol ...for his aggressive behavior. Staff was able to give the resident the injection. Resident was taken to (local hospital) on a psychiatric petition." The incident report revealed the information on this document was "Privileged and Confidential - Not part of the Medical Record." At the time of this interview and record review, the only progress note dated for 5/15/15 was entered at 12:06 PM regarding an order note for the administration of Haloperidol. There were no progress notes, or a late entry note, regarding R101's transfer disposition and/or destination. The DON also confirmed that a hospital transfer notice had not been completed regarding the 5/15/25 incident. The DON said R101 went to a local hospital on 5/15/25 but that R101's transfer information was not in the medical record. A review of the facility document titled, "Transfer and Discharge Guideline", revised 5/5/25 documented in part the following: - This guidance supports safe discharges and transfers for all residents, regardless of initiating			

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	party. - There are a few circumstances when the facility may issue a discharge notice to the resident: A transfer or discharge is necessary for the resident's welfare or well-being and the resident's needs cannot be met in the facility. Documentation for this circumstance: includes facility's attempts to meet the resident's needs. The health and/or safety of others in the facility is in jeopardy. - If the transfer/discharge was an emergency, the notice will be issued as soon as practicable when the safety of the individuals in the facility would be endangered, and an immediate transfer or discharge is required by the resident's urgent medical condition. - The resident's physician and facility staff will document the resident's record: The resident's health status at the time of notice. Reason the services provided by the facility are no longer needed, document discharge needs and discharge plan. - Documentation will include the bases for the transfer and the services to be provided by the receiving health care provider that will meet the resident's needs. On 7/7/25 at 5:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.			
F0842 SS= D	Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract	F0842		

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	under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results			

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	of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: This citation pertains to MI00153114. Based on interview and record review, the facility failed to provide documentation in the EHR (electronic health record) for a psychiatric petition to the hospital for one resident (R101), resulting in missing clinical information regarding the resident's psychiatric status at the time of the transfer. Findings include: It was reported to the State Agency that a resident kicked open locked doors to the fifth and third floor and attacked staff and other residents. A review of the clinical record documented R101 was originally admitted to the facility on 4/9/25 and readmitted on 5/2/25. R101's medical diagnoses included anxiety disorder, mood disorder, unspecified psychosis, and unspecified dementia with other behavioral disturbance. A Minimum Data Set assessment dated 5/8/25 documented moderate cognitive impairment. Census documentation in the EHR revealed a stop billing date of 5/15/25 which indicated R101 no longer resided in the facility. Beginning on 7/7/25 at 2:58 PM, the Director of Nursing (DON) was interviewed regarding R101's status. The DON provided an incident			

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	was going on with him." The DON added because we had to petition R101 out for a psychiatric admission we should have documented "why we weren't able to provide care for him." A review of the facility policy titled, "Charting and Documentation", revised July 2017, documented in part the following: - All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. - The following information is to be documented in the resident medical record: Objective observation, medications administered, treatments or services performed, changes in the resident's condition, events, incidents or accidents involving the resident, and progress toward or changes in the care plan goals and objectives. On 7/7/25 at 5:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.			