

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 814090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 4/29/2025
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NAME OF PROVIDER OR SUPPLIER REGENCY AT WHITMORE LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 8633 N MAIN ST WHITMORE LAKE, MI 48189
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F0000 SS=	<p>INITIAL COMMENTS</p> <p>Regency at Whitmore Lake was surveyed for an Abbreviated survey on 4/29/2025.</p> <p>Intakes: MI00151850, MI00152150</p> <p>Census: 117</p>	F0000		
F0657 SS= D	<p>Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>This citation includes intake MI000152150.</p>	F0657		

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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	<p>Based on interview and record review the facility failed to revise a comprehensive care plan for one out of three residents (Resident #1).</p> <p>Findings Included:</p> <p>Per the facility face sheet Resident #1 (R1) was admitted to the facility on 12/12/2024. Diagnosis included Alzheimer's disease.</p> <p>Review of R1's Brief Interview for Mental Status (BIMS) score revealed that on 12/7/2026 R1 scored a six, and on 2/7/2025, R1 scored a three, both score were indicative of a severe mental impairment.</p> <p>Review of a "Physician's Statement of Competency" dated 12/27/2024, revealed R1 was deemed to be incompetent and not able to make his own medical decisions.</p> <p>Review of R1's progress notes revealed that on 3/30/2025, R1 was found to be lying in a bed with another female resident. The note revealed staff had been following R1 the majority of the day trying to keep R1 and the female resident separate, but were eventually observed in another resident's bed with R1 having his hand down the female's pants.</p> <p>Review of a progress note dated 3/31/2025, revealed R1 was put on one on one supervision. A plan when one staff stays with the resident all the time.</p> <p>The one on one supervision was not written as a Physician's order so all nursing staff would be aware of the one on one status of R1.</p> <p>In an interview on 4/29/2025 at 10:56 AM, Housekeeper "D" stated she had found R1 in a room, which was not his room standing over a</p>			

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	<p>female resident with his hand on her shoulder. Housekeeper "D" said she immediately got help and CNA "E" got up right away and removed R1 and the female resident from the room. Housekeeper "D" stated she did know that staff had been performing a one on one supervision with R1.</p> <p>In an interview on 4/29/2025 at 10:47 AM, CNA "E" said she was made aware of R1 in a room with a female resident who was lying in a bed. CNA "E" said when she got in the room R1 was lying in the bed with the female resident, and R1 had his hands in the female resident's pants.</p> <p>In an interview on 4/29/2025 at 11:12 AM Licensed Practical Nurse (LPN) "F" stated she reported the incident to the Director of Nursing (DON) "B", and kept R1 and the female resident separated.</p> <p>In an interview on 4/29/2025 at 12:05 PM, LPN "G" stated that R1 was a one on one supervision, and stated he did place a CNA with R1 for one on one when he worked. LPN "G" stated he was not the nurse on 4/7/2025.</p> <p>Review of progress notes dated 4/7/2025 revealed R1 was found naked in bed laying next to a female resident.</p> <p>In an interview on 4/29/2025 at 11:26 AM, Certified Nurse Aid (CNA) "C" stated she worked on 4/7/2025 on the 3:00 PM- 11:30 PM shift. CNA "C" said at about 4:00-5:00 PM saw R1 in another resident's room in bed with another female resident, and both residents were naked with their clothes on the floor. CNA "C" stated that no one on one supervision was in place for R1. CNA "C" said she was not aware of any one on one supervision ever being in place for R1, and said she was only told to "keep and eye on</p>			

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	<p>him" (R1). CNA "C" said she was the CNA assigned to R1 on 4/7/2025, but was not told to perform one on one supervision for R1. CNA "C" said the daily assignment sheets was where the nurse would wright down who was one on one supervision, and which staff member was going to be doing that. Upon review of the daily assignment sheet for the date of 4/7/2025 with CNA "C" it was revealed that she was assigned to R1, but no staff member nor resident was written down for one on one supervision. CNA "C" also stated that there was no documentation for when staff perform a one on one for a resident.</p> <p>In an interview on 4/29/2025 at 1:56 PM, LPN "H", who worked the second shift on 4/7/2025, stated she did not recall the incident on 4/7/2025. LPN "H" stated that if a CNA was assigned to be on a one on one with a resident it would have been with a fall risk resident and not with R1.</p> <p>Review of the "Daily Assignment" sheet dated 4/7/2025 for the 3:00-11:30 PM shift revealed CNA "C" was assigned to R1, however was not assigned to perform a one on one with R1.</p> <p>Review of a "Task: Behavior Monitoring" log revealed that on 4/7/2025, R1's sexual behaviors for the 3:00 PM-11:30 PM shift revealed no documentation of whether R1 had any behaviors including sexual behaviors on that day and shift.</p> <p>In an interview on 4/29/2025 at 12:45 PM, Administrator "A" stated there was no documentation of one on one supervision other than the CNA behaviors task, and the daily assignments sheets.</p> <p>Review of R1's care plans revealed that no care plan was put into place that addressed R1's sexual behaviors towards female resident(s) with an intervention of on one on until 4/7/2025.</p>			

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F0689 SS= D	<p>Therefore no care plan was initiated after the incident when R1 was found to be in bed with a female resident on 3/30/2025 with his hands down the females pants.</p> <p>Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:</p> <p>This citation includes intake MI000152150.</p> <p>Based on observation, interview, and record review the facility failed the provide one on one supervision for one out of two residents (Resident #1).</p> <p>Findings Included:</p> <p>Per the facility face sheet Resident #1 (R1) was admitted to the facility on 12/12/2024. Diagnosis included Alzheimer's disease.</p> <p>Review of R1's Brief Interview for Mental Status (BIMS) score revealed that on 12/7/2026 R1 scored a six, and on 2/7/2025, R1 scored a three, both score were indicative of a severe mental impairment.</p> <p>Review of a "Physician's Statement of Competency" dated 12/27/2024, revealed R1 was deemed to be incompetent and not able to make his own medical decisions.</p>	F0689		

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	<p>Review of R1's progress notes revealed that on 3/30/2025, R1 was found to be lying in a bed with another female resident. The note revealed staff had been following R1 the majority of the day trying to keep R1 and the female resident separate, but were eventually observed in another resident's bed with R1 having his hand down the female's pants.</p> <p>Review of a progress note dated 3/31/2025, revealed R1 was put on one on one supervision. A plan when one staff stays with the resident all the time.</p> <p>The one on one supervision was not written as a Physician's order so all nursing staff would be aware of the one on one status of R1.</p> <p>In an interview on 4/29/2025 at 10:56 AM, Housekeeper "D" stated she had found R1 in a room, which was not his room standing over a female resident with his hand on her shoulder. Housekeeper "D" said she immediately got help and CNA "E" got up right away and removed R1 and the female resident from the room. Housekeeper "D" stated she did know that staff had been performing a one on one supervision with R1.</p> <p>In an interview on 4/29/2025 at 10:47 AM, CNA "E" said she was made aware of R1 in a room with a female resident who was lying in a bed. CNA "E" said when she got in the room R1 was lying in the bed with the female resident, and R1 had his hands in the female resident's pants.</p> <p>In an interview on 4/29/2025 at 11:12 AM Licensed Practical Nurse (LPN) "F" stated she reported the incident to the Director of Nursing (DON) "B", and kept R1 and the female resident separated.</p>				

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