STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 29073 Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by other residents for 7 residents (R56, R62, R103, R104, R105, R106, R107) out of 13 residents reviewed for abuse and neglect, resulting in the potential for physical harm, pain and mental anguish. Findings: During an revisit investigation, Facility Reported Incidents (FRIs) since the facility's stated date of compliance (5/14/2024) revealed there were 6 resident-to-resident abuse incidents. Each incident occurred between residents living on the secure unit and are summarized as follows: -In the evening on 5/28/2024 R105 was observed slapping R104's leg and saying, She's in my bed, get out. The nurse on duty at the time heard a commotion but did not witness the resident-to-resident abuse. The other CNA working on the secure unit at the time did not witness the incident. The residents were separated and placed on 15-minute checks. The facility changed rooms for R105. -In the afternoon on 5/29/2024 around shift change a laundry aide near the 500-hall lounge on the secure unit observed R62 using a closed hand to hit R106. The laundry aide said she heard another resident yelling Stop it, stop it and at that point saw R62 hit R106. The laundry aide said R106 told R62 don't hit me. 5 CNAs and an activity assistant were interviewed and did not witness the resident-to-resident abuse. Both residents were placed on 15-minute checks. -At 11:20 AM on 5/30/2024, R107 kicked R62 in the right shin. R62 told R107 to stop kicking me, what the hell are you doing. At the time of the incident, 3 of 4 CNAs were in unknown locations and did not witness the incident. The nurse on duty was at the nurse desk and did not witness the abuse. The CNA who witnessed the altercation had been charting at a kiosk down the hall and reported R62 had been in the lounge at the end of the 500-hall on the secure unit and said something unknown to R107 who was in the hall near the lounge door that may have provoked R107 to kick R62. R107 was place on 15-minute checks as the result of the resident-to-resident abuse. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:30 AM on 5/30/2024, R62 approached the nurse desk where R56 was calling out to another resident. R62 told R56 to stop calling out to knock it off, then stuck R56 on the forehead with a closed hand, leaving a red mark. The residents were separated and R56 was placed on 15-minute checks despite being the victim. The Life Enrichment Director reported R56 appeared upset but did not recall the incident. R62 was already on 15-minute checks from a previous incident where R62 was the victim and returned to a previous dose of medication after a failed gradual dose reduction (GDR) of a psychotropic medication. Two CNAs were in the area near the nurse desk at the time of the incident, however only one CNA witnessed the resident-to-resident abuse. Another CNA was charting on the 400-hall on the secure unit and the 4th CNA was in an unknown location and did not witness the abuse. The nurse on duty was returning from a break and did not witness the abuse. -On 6/5/2024 at 10:30 AM near the activity office on the secure unit, R107 pulled R104's hair, causing R104 to yell in pain. LPN M heard R104 yell and noted R107 backing away from R104 with R104's hair in her hand. LPN M reported R104 saying ow, ow, it hurts and R107 saying she would do it again. R107 was placed on 15-minute checks and prescribed an antipsychotic as the result of an overall increase in behaviors and the resident-to-resident abuse. At the time of the incident, one CNA had been off the unit taking a resident to a meeting, 2 CNAs were on a break, a fourth CNA was providing patient care, LPN M was passing medications, and the activity assistant was in the lounge on the 500-hall of the secure unit running an activity. -In the afternoon on 6/5/2024 R106 and R103 were seated in the dining room for an activity. R62 had been in and out of the room a few times during the activity. R62 returned to the activity and used an open hand to strike R106. R106 backed away from the table and used an open hand to strike R62 on the cheek. As the activity assistant was redirecting R106, R62 struck R103. R103 was placed on 15-minute checks as the result of the incident, despite not being a perpetrator. R106 and R62 were already on 15-minute checks due to previous altercations. No other staff witnessed the resident-to-resident abuse. R62 was placed on a 1:1 for supervision. During an interview on 6/11/2024 at 3:02 PM, the Nursing Home Administrator (NHA) reported that in each of the FRI's reported to the state agency, the facility did not believe any abuse occurred. According to the NHA, all of the residents involved in each of the reports was severely cognitively impaired and therefore could not be willful. The facility abuse prohibition policy was reviewed with the facility administrator at this time. Review of the facility Abuse Prohibition Policy last reviewed 9/9/2022 reflected Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. The policy definitions specified Abuse means the willful infliction of injury, unreasonable confinement or punishment with resulting physical harm, pain or mental anguish. This also includes the depravation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all guests/residents, irrespective of any mental or physical condition, may cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Physical Abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview, and record review, the facility failed to report allegations of abuse for three (Resident #13, #59 and #62) of 5 reviewed, resulting in allegations of sexual abuse that were not reported to the State Agency and the potential for further allegations of abuse to go unreported. Findings include: Review of the facility, Abuse Prohibition Policy, dated 9/9/22, reflected, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience that are not required to treat the guest's/resident's medical symptoms .Sexual Abuse is non-consensual sexual contact of any type with a guest/resident .Sexual abuse includes, but is not limited to: unwanted intimate touching of any kind especially of breasts or perineal area; all types of sexual assault or battery, such as rape, sodomy, fondling and/or intercourse or coerced nudity; forced observation of masturbation and/or pornography . Resident #13 (R13) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R13 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included Alzheimer, heart disease, heart failure, pacemaker, hypertension (high blood pressure), cerebral vascular accident, frequent falls, anxiety and depression . The MDS reflected R13 had a BIM (assessment tool) score of 8 which indicated his ability to make daily decisions was moderately impaired. Resident #62(R62) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R62 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included Dementia with agitation and behavior disturbance, neurocognitive disorder due to known physiological condition, need for continuous supervision, and hypertension (high blood pressure). The MDS reflected R62 had a BIM (assessment tool) score of 6 which indicated her ability to make daily decisions was severely impaired. Resident #59(R59) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R59 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included aphyasia, hypertension (high blood pressure), cerebral vascular accident, and depression . The MDS reflected R59 had a BIM (assessment tool) score of 7 which indicated his ability to make daily decisions was severely impaired. During an observation on 4/16/24 at 11:05 AM, R13 was noted to be in bed with eyes closed with no roommate noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13 Nurse Progress Notes, dated 4/16/2024 at 2:59 a.m., reflected, Res is on 15 min checks r/t behaviors. Noted during dinner in dinning room, was giving another female Res food from used trays already put in cart. When explained to Res that female Res was on a special diet and could not eat that food, Res stood up and pulled his fist back attempting to hit staff. Demanded staff return food to her and stated she is not on a special diet! He also stated that she is my wife. Res stood and pulled fist back 3 times while staff was attempting to explain situation to Res. Female Res left the dinning room. Res calmed at this point. During a telephone interview on 4/17/24 at 2:44 PM, Licensed Practical Nurse(LPN) M reported R13 was currently on 15 minute checks for frequent nudity and described R13 as cranky, impulsive, impatient, and have inappropriate adult behaviors. LPN M reported R13 had history of violent behaviors if prompted and staff attempted to keep separate from other residents. LPN M reported R13 asked other female residents and staff to have sex with him, would be located in halls nude and often start screaming if staff attempted to removed from situations. LPN M reported did not observe R13 touch R62 on 4/6/24 and reported housekeeping staff reported to her and was unsure if investigation was completed. LPN M reported was unable to recall if incident was reported to management and reported unit managers review all Progress Notes. LPN M reported R13 and R62 were separated because female resident was telling R13, no. LPN M reported neither R13 or R62 were their own responsible party. LPN M reported did not think at time R13 touching R62 was allegation of sexual abuse because R62 does not like anyone close or touching her and responded because of that. Review of the Nurse Progress Note, dated 4/6/2024 at 2:18 p.m., reflected, Resident behavior note: After lunch it was observed by housekeeping staff, resident self-propelled his wheelchair next to a female resident who was seated in front of the nurses station. He grabbed her leg and attempted to place his hand on her groin. Resident was removed from the area, staff requested resident stay away from the female residents. Female resident was very upset and told him to remove his hand. [Named R13] did not comply until staff intervened. Male resident was very upset and began yelling at the staff that he can do what he wants to do. Housekeeping notified CNA who continued to keep resident separated from female residents. Review of R13 Nurse Progress Note, dated 4/1/24, reflected, Res is on 15 min checks. Has wandered out of room x 3. Has not had clothes on and touching self in privates. Review of R13 Provider Note, dated 4/1/24, reflected, Staff note resident frequently takes all his close off. He mainly stays in his room in this states, but has attempted to walk around facility. Review of R13 Nurse Progress Note, dated 3/23/24, reflected, .Staff reported there was a conversation between [named R13] and a female resident, [named R13] asked the female resident do you want to fuck. Staff interviened and instructed male resident not to ask those questions because it is inappropriate. Female resident agreed and male resident said ok. Review of the Nurse Progress Note, dated 3/20/2024 at 4:24 a.m., reflected, Res noted walking around room with no bottoms on. Comes to door of room and is noted touching self and it is erect. Res states he likes to be naked at night he sleeps better. And states he is not going to stop exposing self. Review of R13 Behavior Monitoring Tasks, dated 3/20/24 through 4/18/24, reflected 11 occasions of sexually inappropriate behaviors, not including 4/6/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 2:16 PM, Nursing Home Administrator(NHA) A verified R13 did not have any Incident/Accident(I/A) reports in the past year. NHA A reported IA reports included all incidents not just falls. During an interview on 4/17/24 at 3:37 PM, Certified Nurse Aid (CNA) N reported R13 preferred to not wear clothes and had to frequently encourage R13 to put on clothes before exiting room. During an interview on 4/17/24 at 4:00 PM, CNA O reported R13 was on 15 minute checks related to sexually inappropriate behaviors with female residents and was not own responsible person. CNA O reported R13 makes sexually inappropriate comments to both residents and staff. CNA O reported had not witnessed R13 touch a female resident, however, if it was witnessed CNA O reported would separate residents and report to nurse immediately because potential allegation of sexual abuse. During a telephone interview on 4/17/24 at 4:45 PM, Confidential Staff (CS) P reported R13 was on 15 minute checks for nudity, and aggressive behaviors. CS P reported behavior monitoring was difficult related to staffing concerns with three CNA staff and one nurse at times with eight 2 person assist residents on secure unit., and up to five residents that require 15 minute checks at one time. CS P reported example of sexual abuse allegation was unwanted touching. During record review on 4/18/24 at 9:45 AM, NHA A provided list of abuse allegations for past six months that did not include R13. During a confidential telephone interview on 4/18/24 at 10:31 AM, Confidential Staff (CS) Q reported heard R13 had sexually inappropriate behaviors including touching female residents inappropriately and that was one reason R13 was on 15 minute behavior checks. CS Q reported was present on 4/7/24 when CNA R caught R59 and R62 with hands down each others pants on couch in activity room of secure unit. CS Q reported LPN M was notified immediately who reported to management. CS Q reported if she would have witnessed situation would immediately separate residents, report immediately to nurse because allegation of sexual abuse. CS Q reported neither R59 or R62 were able to consent to sexual relations with diagnosis of advanced dementia. CS Q reported often three CNA staff and one nurse on secure unit day shift with several behaviors and impossible to monitor all residents at all times. CS Q reported when R59 and R62 were located on couch together staff were attempting to assist other residents to and from scheduled activities and no staff available to monitor residents in common area. CS Q reported activities are not engaging for residents on secure unit and would have less behaviors if more activities. Review of R59 Nursing Progress Note, dated 4/7/24, reflected, At approximately 1020 CNA notified CNA that male resident and a female resident were in the activity (the end of the 500 hallway) room following an activity. When staff went in to remove male resident he was observed inappropriately touching himself. Staff immediately separated the residents and are continuing observation of both male and female resident. DON was notified via phone call at 10:44 AM. During a telephone interview on 4/18/24 at 11:55 AM, HSK T reported worked on 4/6/24 at the time of R13 and R62 incident. HSK T reported heard R62 yell, Don't touch me there. HSK T reported turned head and observed R13 near R62 located by Nurse station. HSK T reported HSK U observed the incident and reported to LPN M. HSK T reported if she would have witnessed would report to nurse because possible allegation of sexual abuse. HSK T reported was new employee and did not recall receiving abuse education. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 12:25 PM, HSK U reported had worked at the facility about 2 months and did not recall receiving abuse training from facility and was unable to name five types of abuse. HSK U reported was working on 4/6/24 and witnessed the resident to resident incident between R13 and R62 on the secure unite. HSK U reported was standing by shower room door located by Nurse Station and overheard R62 yell, don't touch me there. HSK U reported turned to look at both R13 and R62 located by the nurse station and observed R13 moving hand up R62's inner thigh to crotch area. HSK U reported turned to ask HSK T R13 name and as soon as R13 heard his name he moved away from R62. HSK U reported R62 was sitting in stationary chair and R13 was next to R62 sitting in wheelchair. HSK U reported knowledge of R13 history with preferences, including being naked in room and self pleasure behaviors and stated, that is why it caught my attention. HSK U reported overheard R13 say, did you like that? to R62 before R13 moved away from R62. During an interview on 4/18/24 at 1:00 PM, CNA G reported worked 4/7/24 did not witness R59 and R62 incident entered activity room, located at the end of the women's hall secure unit, after CNA R was attempting to separate R59 and R62. CNA G reported R59 and R62 were both on couch and CNA R reported R59 pants open with genital area exposed to R62. CNA G reported was reported to nurse because allegation of abuse. During a telephone interview on 4/18/24 at 1:15 PM, LPN M reported CNA R reported to her that R59 was inappropriately touching himself with genitals exposed to R62 while both sitting on couch in activity room on 4/7/24. LPN M reported incident immediately reported to the Director of Nursing(DON) B by telephone because allegation of sexual abuse. LPN M reported staff attempted to keep R59 off women's hall but was at the time of just before or just after activity and other staff assisting other residents. During a telephone interview on 4/18/24 at 1:44 PM, CNA R reported worked on 4/7/24 and witnessed incident between R59 and R62 in activity room. CNA R reported entered activity room and found R59 and R62 sitting on couch together. CNA R reported R59 had pants down with genitals exposed touching himself and R62 was staring at R59's genitals. CNA R reported immediately separated residents and redirected R59 from couch while R62 started yelling and became upset. CNA R reported incident to LPN M immediately because inappropriate behavior and called DON B. CNA R reported would be annoyed if either resident was her family and that behavior happened. CNA R reported three CNA staff and one nurse at that time and staff were assisting other residents on the unit at the time and no staff in activity room that that time. CNA R reported neither R59 or R62 were able to consent. Review of R13, R62 and R59 Electronic Medical Record, dated 4/6/24 through 4/16/24, reflected no evidence of social work follow up post 4/6/24 and 4/7/24 incidents. During an interview on 4/18/24 at 2:37 PM, DON B reported was responsible for staff schedules and used onshift system that used budget and facility census to staff facility. DON B reported goal for secure unit was one nurse and three to five CNA staff on day shift. DON B verified on 4/5/24, 4/6/24, and 4/7/24 the secure unit had one nurse and three CNA staff on day shift. DON B reported R59 and R62 were unable to consent and not their own responsible party. DON B reported did receive call from LPN M on 4/7/24 related to R59 and R62 incident and did not report to State of Michigan or Nursing Home Administrator (NHA) A because did not consider allegation of abuse related to information provided. DON B reported investigation was not completed. DON B reported allegation of sexual abuse would include non-consensual, unwanted touching. DON B reported was not aware of incident on 4/6/24 related to R13 and R62. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 3:45 PM, NHA A had been the facility Administrator for about 1.5 years, including abuse coordinator. NHA A reported would expect staff to notify NHA A immediately of all allegations of abuse if in building, and if not charge nurse then they would notify NHA immediately. NHA A reported initial investigation would then be started. NHA A reported she determines need for investigation after determining if intent through initial investigation. NHA A was queried, does it mater if intent or not related to residents with dementia? NHA A stated, depends. NHA A reported did not recall being informed of incident on 4/6/24 related to R13 and R62. NHA A reported recalled R13 on 15 minute checks related to inappropriate sexual comments and nudity. NHA A reported R13, R62 and R59 were not consenting adults and R62 had a very involved husband, with involved family who had recent discussion of providing R62 and husband private visits. NHA A reported unwanted intimate touch can be an example of sexual abuse. NHA A reported R13 and R62 inappropriate touching should have been reported to NHA A as allegation sexual abuse with need for investigation. NHA A reported aware R62 and R59 had history of believing one thinking the other was their spouse, however, no knowledge details related to 4/7/24 incident and reported should have been reported to the State Agency and investigation completed and was not done. NHA A reported they would expect Social Work to follow up with all allegations of abuse for three days and document in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to ensure the protection of residents and thoroughly investigate allegations of abuse that involved 3 residents (Resident #13, #59 and #62) of 5 reviewed for abuse, resulting in the potential for further abuse to occur and allegations of abuse not being thoroughly investigated. Findings include: Review of the facility, Abuse Prohibition Policy, dated 9/9/22, reflected, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience that are not required to treat the guest's/resident's medical symptoms .Sexual Abuse is non-consensual sexual contact of any type with a guest/resident .Sexual abuse includes, but is not limited to: unwanted intimate touching of any kind especially of breasts or perineal area; all types of sexual assault or battery, such as rape, sodomy, fondling and/or intercourse or coerced nudity; forced observation of masturbation and/or pornography . Resident #13(R13) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R13 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included Alzheimer, heart disease, heart failure, pacemaker, hypertension (high blood pressure), cerebral vascular accident, frequent falls, anxiety and depression . The MDS reflected R13 had a BIM (assessment tool) score of 8 which indicated his ability to make daily decisions was moderately impaired. Resident #62(R62) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R62 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included Dementia with agitation and behavior disturbance, neurocognitive disorder due to known physiological condition, need for continuous supervision, and hypertension (high blood pressure). The MDS reflected R62 had a BIM (assessment tool) score of 6 which indicated her ability to make daily decisions was severely impaired. Resident #59(R59) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R59 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included aphyasia, hypertension (high blood pressure), cerebral vascular accident, and depression . The MDS reflected R59 had a BIM (assessment tool) score of 7 which indicated his ability to make daily decisions was severely impaired. During an observation on 4/16/24 at 11:05 AM, R13 was noted to be in bed with eyes closed with no roommate noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13 Nurse Progress Notes, dated 4/16/2024 at 2:59 a.m., reflected, Res is on 15 min checks r/t behaviors. Noted during dinner in dinning room, was giving another female Res food from used trays already put in cart. When explained to Res that female Res was on a special diet and could not eat that food, Res stood up and pulled his fist back attempting to hit staff. Demanded staff return food to her and stated, she is not on a special diet! He also stated that she is my wife. Res stood and pulled fist back 3 times while staff was attempting to explain situation to Res. Female Res left the dinning room. Res calmed at this point. During a telephone interview on 4/17/24 at 2:44 PM, Licensed Practical Nurse(LPN) M reported R13 was currently on 15 minute checks for frequent nudity and described R13 as cranky, impulsive, impatient, and have inappropriate adult behaviors. LPN M reported R13 had history of violent behaviors if prompted and staff attempted to keep separate from other residents. LPN M reported R13 asked other female residents and staff to have sex with him, would be located in halls nude and often start screaming if staff attempted to removed from situations. LPN M reported did not observe R13 touch R62 on 4/6/24 and reported housekeeping staff reported to her and was unsure if investigation was completed. LPN M reported was unable to recall if incident was reported to management and reported unit managers review all Progress Notes. LPN M reported R13 and R62 were separated because female resident was telling R13, no. LPN M reported neither R13 or R62 were their own responsible party. LPN M reported did not think at time R13 touching R62 was allegation of sexual abuse because R62 does not like anyone close or touching her and responded because of that. Review of the Nurse Progress Note, dated 4/6/2024 at 2:18 p.m., reflected, Resident behavior note: After lunch it was observed by housekeeping staff, resident self-propelled his wheelchair next to a female resident who was seated in front of the nurses station. He grabbed her leg and attempted to place his hand on her groin. Resident was removed from the area, staff requested resident stay away from the female residents. Female resident was very upset and told him to remove his hand. [Named R13] did not comply until staff intervened. Male resident was very upset and began yelling at the staff that he can do what he wants to do. Housekeeping notified CNA who continued to keep resident separated from female residents. Review of R13 Nurse Progress Note, dated 4/1/24, reflected, Res is on 15 min checks. Has wandered out of room x 3. Has not had clothes on and touching self in privates. Review of R13 Provider Note, dated 4/1/24, reflected, Staff note resident frequently takes all his close off. He mainly stay is in his room in this states, but has attempted to walk around facility. Review of R13 Nurse Progress Note, dated 3/23/24, reflected, .Staff reported there was a conversation between [named R13] and a female resident, [named R13] asked the female resident, do you want to fuck. Staff intervened and instructed male resident not to ask those questions because it is inappropriate. Female resident agreed and male resident said ok. Review of the Nurse Progress Note, dated 3/20/2024 at 4:24 a.m., reflected, Res noted walking around room with no bottoms on. Comes to door of room and is noted touching self and it is erect. Res states he likes to be naked at night he sleeps better. And states he is not going to stop exposing self. Review of R13 Behavior Monitoring Tasks, dated 3/20/24 through 4/18/24, reflected 11 occasions of sexually inappropriate behaviors, not including 4/6/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 2:16 PM, Nursing Home Administrator(NHA) A verified R13 did not have any Incident/Accident(I/A) reports in the past year. NHA A reported IA reports included all incidents not just falls. During an interview on 4/17/24 at 3:37 PM, Certified Nurse Aid(CNA) N reported R13 preferred to not wear cloths and had to frequently encourage R13 to put on cloths before exiting room. During an interview on 4/17/24 at 4:00 PM, CNA O reported R13 was on 15 minute checks related to sexually inappropriate behaviors with female residents and was not own responsible person. CNA O reported R13 makes sexually inappropriate comments to both residents and staff. CNA O reported had not witnessed R13 touch a female resident, however, if it was witnessed CNA O reported would separate residents and report to nurse immediately because potential allegation of sexual abuse. During a telephone interview on 4/17/24 at 4:45 PM, Confidential Staff(CS) P reported R13 was on 15 minute checks for nudity, and aggressive behaviors. CS P reported behavior monitoring was difficult related to staffing concerns with three CNA staff and one nurse at times with eight 2 person assist residents on secure unit., and up to five residents that require 15 minute checks at one time. CS P reported example of sexual abuse allegation was unwanted touching. During record review on 4/18/24 at 9:45 AM, NHA A provided list of abuse allegations for past six months that did not include R13. During a confidential telephone interview on 4/18/24 at 10:31 AM, Confidential Staff (CS) Q reported heard R13 had sexually inappropriate behaviors including touching female residents inappropriately and that was one reason R13 was on 15 minute behavior checks. CS Q reported was present on 4/7/24 when CNA R caught R59 and R62 with hands down each others pants on couch in activity room of secure unit. CS Q reported LPN M was notified immediately who reported to management. CS Q reported if she would have witnessed situation would immediately separate residents, report immediately to nurse because allegation of sexual abuse. CS Q reported neither R59 or R62 were able to consent to sexual relations with diagnosis of advanced dementia. CS Q reported often three CNA staff and one nurse on secure unit day shift with several behaviors and impossible to monitor all residents at all times. CS Q reported when R59 and R62 were located on couch together staff were attempting to assist other residents to and from scheduled activities and no staff available to monitor residents in common area. CS Q reported activities are not engaging for residents on secure unit and would have less behaviors if more activities. Review of R59 Nursing Progress Note, dated 4/7/24, reflected, At approximately 1020 CNA notified CN that male resident and a female resident were in the activity (the end of the 500 hallway) room following an activity. When staff went in to remove male resident he was observed inappropriately touching himself. Staff immediately separated the residents and are continuing observation of both male and female resident. DON was notified via phone call at 1044. During a telephone interview on 4/18/24 at 11:55 AM, HSK T reported worked on 4/6/24 at the time of R13 and R62 incident. HSK T reported heard R62 yell, Don't touch me there. HSK T reported turned head and observed R13 near R62 located by Nurse station. HSK T reported HSK U observed the incident and reported to LPN M. HSK T reported if she would have witnessed would report to nurse because possible allegation of sexual abuse. HSK T reported was new employee and did not recall receiving abuse education. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 12:25 PM, HSK U reported had worked at the facility about 2 months and did not recall receiving abuse training from facility and was unable to name five types of abuse. HSK U reported was working on 4/6/24 and witnessed the resident to resident incident between R13 and R62 on the secure unite. HSK U reported was standing by shower room door located by Nurse Station and overheard R62 yell, don't touch me there. HSK U reported turned to look at both R13 and R62 located by the nurse station and observed R13 moving hand up R62's inner thigh to crotch area. HSK U reported turned to ask HSK T R13 name and as soon as R13 heard his name he moved away from R62. HSK U reported R62 was sitting in stationary chair and R13 was next to R62 sitting in wheelchair. HSK U reported knowledge of R13 history with preferences, including being naked in room and self pleasure behaviors and stated, that is why it caught my attention. HSK U reported overheard R13 say, did you like that? to R62 before R13 moved away from R62. During an interview on 4/18/24 at 1:00 PM, CNA G reported worked 4/7/24 did not witness R59 and R62 incident entered activity room, located at the end of the women's hall secure unit, after CNA R was attempting to separate R59 and R62. CNA G reported R59 and R62 were both on couch and CNA R reported R59 pants open with genital area exposed to R62. CNA G reported was reported to nurse because allegation of abuse. During a telephone interview on 4/18/24 at 1:15 PM, LPN M reported CNA R reported to her that R59 was inappropriately touching himself with genitals exposed to R62 while both sitting on couch in activity room on 4/7/24. LPN M reported incident immediately reported to the Director of Nursing(DON) B by telephone because allegation of sexual abuse. LPN M reported staff attempted to keep R59 off women's hall but was at the time of just before or just after activity and other staff assisting other residents. During a telephone interview on 4/18/24 at 1:44 PM, CNA R reported worked on 4/7/24 and witnessed incident between R59 and R62 in activity room. CNA R reported entered activity room and found R59 and R62 sitting on couch together. CNA R reported R59 had pants down with genitals exposed touching himself and R62 was staring at R59's genitals. CNA R reported immediately separated residents and redirected R59 from couch while R62 started yelling and became upset. CNA R reported incident to LPN M immediately because inappropriate behavior and called DON B. CNA R reported would be annoyed if either resident was her family and that behavior happened. CNA R reported three CNA staff and one nurse at that time and staff were assisting other residents on the unit at the time and no staff in activity room that that time. CNA R reported neither R59 or R62 were able to consent. Review of R13, R62 and R59 Electronic Medical Record, dated 4/6/24 through 4/16/24, reflected no evidence of social work follow up post 4/6/24 and 4/7/24 incidents. During an interview on 4/18/24 at 2:37 PM, DON B reported was responsible for staff schedules and used onshift system that used budget and facility census to staff facility. DON B reported goal for secure unit was one nurse and three to five CNA staff on day shift. DON B verified on 4/5/24, 4/6/24, and 4/7/24 the secure unit had one nurse and three CNA staff on day shift. DON B reported R59 and R62 were unable to consent and not their own responsible party. DON B reported did receive call from LPN M on 4/7/24 related to R59 and R62 incident and did not report to State of Michigan or Nursing Home Administrator(NHA) A because did not consider allegation of abuse related to information provided. DON B reported investigation was not completed. DON B reported allegation of sexual abuse would included non-consensual, unwanted touching. DON B reported was not aware of incident on 4/6/24 related to R13 and R62. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 3:45 PM, NHA A had been the facility Administrator for about 1.5 years, including abuse coordinator. NHA A reported would expect staff to notify NHA A immediately of all allegations of abuse if in building, and if not charge nurse then they would notify NHA immediately. NHA A reported initial investigation would then be started. NHA A reported she determines need for investigation after determining if intent through initial investigation. NHA A was queried, does it mater if intent or not related to residents with dementia? NHA A stated, depends. NHA A reported did not recall being informed of incident on 4/6/24 related to R13 and R62. NHA A reported recalled R13 on 15 minute checks related to inappropriate sexual comments and nudity. NHA A reported R13, R62 and R59 were not consenting adults and R62 had a very involved husband, with involved family who had recent discussion of providing R62 and husband private visits. NHA A reported unwanted intimate touch can be an example of sexual abuse. NHA A reported R13 and R62 inappropriate touching should have been reported to NHA A as allegation sexual abuse with need for investigation. NHA A reported aware R62 and R59 had history of believing one thinking the other was their spouse, however, no knowledge details related to 4/7/24 incident and reported should have been reported to the State Agency and investigation completed and was not done. NHA A reported would expect Social Work to follow up with all allegations of abuse for three days and document in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46955 Based on observation, interview, and record review, the facility failed to implement comprehensive care plans for 1 (Resident #56) of 18 residents reviewed, resulting in the potential for unmet care needs and impaired wound healing/wound deterioration. Findings include: Review of the medical record revealed that Resident #56 (R56) was initially admitted to facility on 11/14/22 with ongoing diagnoses including unspecified dementia, adult failure to thrive, difficulty in walking, generalized muscle weakness, and pressure ulcer of right heel. Review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/11/24 reflected that R56 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 7 (severe cognitive impairment). Section M of the same MDS revealed that R56 was at risk for developing pressure ulcers, had an unhealed facility acquired stage 3 pressure ulcer, and was not on a turning/repositioning program. Review of R56's ADL (Activities of Daily Living) Care Plan reflected that R56 required extensive assist with bed mobility, dressing, and bathing; was dependent for toilet use and transfers; and required supervision for meals. During an observation and interview on 4/16/24 at 10:21 AM, R56 was observed sitting in a high back wheelchair in an activity room at the end of the hallway on which she resided. Blue cushioned boots were noted to R56's bare feet which were positioned on a blue L shaped foot cradle attached to R56's wheelchair foot pedals. R56 opened eyes when questioned as to how she was doing, stated What do you want?, prior to closing eyes and providing no additional responses to follow-up questions. On 4/16/24 at 1:26 PM, R56 was observed lying in bed, on back, with the head of her bed at an approximate 30-degree angle. R56's eyes were noted to be closed and her bilateral legs were observed to be bent at knees with bottom of bare feet and heels resting directly on mattress. A soft, blue device used to bridge/offload/float (elevating the heel off the bed so it is free of pressure) heels was observed to be positioned against the foot of the bed not in use. R56's blue cushioned boots were noted on the counter just to the left of R56's television. On 4/16/24 at 3:05 PM, R56 was observed lying in bed, on back, with the head of the bed positioned at the same angle as in prior observation. R56's eyes were noted to remain closed, her lower extremities remained bent at knees but now positioned toward the right with R56's bare left medial foot and heel and bare right lateral foot and heel in direct contact with the mattress. R56's blue heel offloading device remained at the foot of the bed and blue cushioned boots were noted to remain on the counter just to the left of the television. On 4/17/24 at 9:44 AM, R56 was again observed sitting in a high back wheelchair in the activity room with the back of the wheelchair reclined slightly. R56 was observed to have blue nonskid socks on feet with feet and heels positioned directly on the foot cradle attached to R56's wheelchair foot pedals. R56's cushioned blue boots noted to remain on the counter, in her room, just to the left of the television. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 12:27 PM, R56 was observed eating lunch in the dining room located just after entry to locked unit. Blue nonskid socks were noted to R56's feet with feet positioned directly on the foot cradle attached to the foot pedals with R56's bilateral feet and heels in direct contact with the base of the cradle. R56's cushioned blue boots noted to remain on the counter, in her room, just to the left of the television. On 4/17/24 at 2:04 PM, R56 was observed with eyes closed, lying in bed positioned toward right side with legs bent at the knees. R56 was noted to have blue nonskid socks on feet with lower extremities positioned on blue elevating device with left medial foot and heel and right lateral foot and heel laying directly on device. Review of R56's medical record completed with the following findings noted: Skin & Wound Evaluation dated 3/19/24 at 11:47 AM reflected an in-house acquired Stage 3 pressure ulcer at right heel present since 4/4/23. The treatment section, of the same evaluation, was noted to include the use of a heel suspension/protection device with the progress section reflecting that the wound was stable with provided education indicated to Continue to encourage resident to allow staff in repositioning her frequently and to wear prevalon boots [heel protection boots that lift the heel to help prevent the development of heel pressure injuries] to both feet. Educate staff to be sure resident has Prevalon boot on and proper care. Skin & Wound Evaluation dated 4/2/24 at 10:42 AM reflected the same Stage 3 right heel pressure injury, the treatment section reflected use of a heel suspension/protection device, with the progress section reflecting wound improvement and provided education indicated to include Continue to encourage resident to allow staff in repositioning her frequently and to wear prevalon boots to both feet. Educate staff to be sure resident has Prevalon boot on and proper care. Skin & Wound Evaluation dated 4/9/24 at 9:43 AM reflected the same Stage 3 right heel pressure injury, the treatment section reflected use of prevalon boots, with the progress section reflecting wound improvement and provided education indicated to include Continue to educate staff to apply prevlon [sic] boots while up in chair and float heels while in bed. Skin & Wound Evaluation dated 4/16/24 at 10:29 AM reflected the same Stage 3 right heel pressure injury, the treatment section reflected use of prevalon boots, with the progress section reflecting wound improvement and provided education indicated to include Continue to educate staff to apply prevlon [sic] boots while up in chair and float heels while in bed. Order dated 1/11/2024 at 7:39 AM stated, Ensure Prevalon Boots are on Bilateral Feet every shift. Review of the corresponding Treatment Administration Record (TAR) dated 4/1/24-4/30/24 reflected the boots to be signed out as in place for every day and night shift from 4/1/24 through day shift of 4/17/24 with no refusal of boots indicated. Care Plan Focus .actual impaired skin integrity related to Pressure injury, R [right] heel, stage 3 . with a 12/1/23 date of revision included an associated Intervention with a 10/18/23 date of revision which stated, apply prevalon boots to [R56's name] while in bed, reapply when she removes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Kardex (tool used by the Certified Nurse Aide to guide them as to the care needs of a specific resident) reflected the identical care plan intervention to apply prevalon boots to [R56's name] while in bed, reapply when she removes. Physician Assistant (PA) Progress Notes with an indicated Date of Service of 4/16/24 stated, .Visit type: Wound Care .History of Present Illnesses .Resident is being seen today for R heel wound .The surrounding tissue is fragile .Assessment and Plans .continue pressure relief boots . Review of Progress Notes over the last 30 days included no documentation to reflect R56's refusal of the ordered prevalon boots. Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] = 16 and 4/14/24 = 17 with both scores reflecting that R56 is At Risk for the development of pressure sores. In an interview on 4/17/24 at 2:06 PM, Certified Nurse Aide (CNA) G confirmed familiarity with R56 and stated that he was her assigned aide that date. CNA G stated that R56 was confused but that she could sometimes make her needs known and that she required extensive to total assist with bathing, dressing, and bed mobility. CNA G stated that R56 had mushy/soft heels and that her heels were floated while in bed with either the heel bridge cushion or her heels up boots. CNA G stated that R56 wore nonskid socks while up in wheelchair, denying that she used her cushioned boots when out of bed, but stated that she did have a special device on her wheelchair foot pedals to help in the positioning of her feet for safety. During the same interview, upon entering R56's room, R56's lower legs, heels, and feet were observed to be resting directly on a blue heel elevating device with CNA G stating that he considered R56's heels to be bridged as they were not resting directly on the mattress. In an interview on 4/17/24 at 2:13 PM, Licensed Practical Nurse (LPN) E confirmed familiarity with R56 and that she was her assigned nurse that date. Per LPN E, R56 had fluctuating cognition, required extensive assist with all cares, and had a resolving wound at her right heel. LPN E stated that R56 wore heel protector boots for pressure reduction continuously during the day and at night as otherwise there would be too much pressure to her heels, that the boots were removed for cares, skin checks, and treatments, and that the boots were an ordered treatment that were signed out on the TAR. LPN E confirmed that she had signed the boots out as administered earlier that date as thought that she had them on and had not been informed by the staff that she had refused or removed them. LPN E further confirmed that R56 generally allowed staff to place the boots both when in bed and in her wheelchair and to her knowledge and her prior experience with R56, that she did not generally refuse boot usage. In an interview on 4/17/24 at 2:24 PM, Registered Nurse/Unit Manager (RN/UM) C confirmed familiarity with R56, stated that she had an active but improving right heel pressure ulcer that she followed weekly with ongoing topical treatment along with pressure reduction. RN/UM C stated that R56 had an order for prevalon boots to be worn when in an out of bed but that sometimes she did not like the boots while in bed so that her heels were then floated so that no pressure was on her heels. Upon review of R56's medical record, RN/UM C confirmed that the 1/11/24 order to ensure the prevalon boots were on bilateral feet every shift was accurate as the boots should be in place both when in bed and in her wheelchair but that R56's care plan was not accurate as only indicated use while in bed and that she would be updating to accurately reflect usage while in wheelchair as well. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview, upon entering R56's room, RN/UM C stated that as R56's lower legs, heels, and feet were resting directly on the heel elevating device that she would not consider her heels to be bridged but that R56 may have pulled her legs up since initial placement. RN/UM C was observed to remove R56's right nonskid sock with right heel noted to present with red to brown dry/flaky tissue surrounded by intact pink scar tissue. RN/UM C stated that although R56's right heel skin was intact, it was fragile and mushy and that would expect that if R56 was not tolerating or was refusing the use of the prevalon boots that the nurse was notified so that documentation could be completed. Per RN/UM C, she had to continually educate staff regarding the proper usage and placement of R56's prevalon boots as would sometimes see that she did not have them on as stated that sometimes staff just forgot and that at other times, staff were just unfamiliar with R56 as the CNAs routinely rotated to different halls. Review of the same Care Plan Focus .actual impaired skin integrity related to Pressure injury, R [right] heel, stage 3 . with a 12/1/23 date of revision was completed again on 4/17/23 at 3:15 PM. The Care Plan Intervention pertaining to R56's prevalon boots was now noted to state, apply prevalon boots to [R56's name] while up in wheelchair and in bed, reapply when she removes with an indicated revision date of 4/17/24. Review of the facility policy titled Care Planning with a 6/24/21 revised date stated, Purpose .Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to ensure sufficient levels of nursing staff to meet resident needs for three residents (Resident #13, #59, and #62), resulting in allegations of sexual abuse, fall with fracture, and the potential for unmet care needs and facility residents to not attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #13(R13) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R13 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included Alzheimer, heart disease, heart failure, pacemaker, hypertension (high blood pressure), cerebral vascular accident, frequent falls, anxiety and depression . The MDS reflected R13 had a BIM (assessment tool) score of 8 which indicated his ability to make daily decisions was moderately impaired. Resident #62(R62) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R62 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included Dementia with agitation and behavior disturbance, neurocognitive disorder due to known physiological condition, need for continuous supervision, and hypertension (high blood pressure). The MDS reflected R62 had a BIM (assessment tool) score of 6 which indicated her ability to make daily decisions was severely impaired. Resident #59(R59) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R59 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included aphyasia, hypertension (high blood pressure), cerebral vascular accident, and depression . The MDS reflected R59 had a BIM (assessment tool) score of 7 which indicated his ability to make daily decisions was severely impaired. During an observation on 4/16/24 at 11:05 AM, R13 was noted to be in bed with eyes closed with no roommate noted. Review of R13 Nurse Progress Notes, dated 4/16/2024 at 2:59 a.m., reflected, Res is on 15 min checks r/t behaviors. Noted during dinner in dinning room, was giving another female Res food from used trays already put in cart. When explained to Res that female Res was on a special diet and could not eat that food, Res stood up and pulled his fist back attempting to hit staff. Demanded staff return food to her and stated she is not on a special diet! He also stated that she is my wife. Res stood and pulled fist back 3 times while staff was attempting to explain situation to Res. Female Res left the dinning room. Res calmed at this point. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/17/24 at 2:44 PM, Licensed Practical Nurse(LPN) M reported R13 was currently on 15 minute checks for frequent nudity and described R13 as cranky, impulsive, impatient, and have inappropriate adult behaviors. LPN M reported R13 had history of violent behaviors if prompted and staff attempted to keep separate from other residents. LPN M reported R13 asked other female residents and staff to have sex with him, would be located in halls nude and often start screaming if staff attempted to removed from situations. LPN M reported did not observe R13 touch R62 on 4/6/24 and reported housekeeping staff reported to her and was unsure if investigation was completed. LPN M reported was unable to recall if incident was reported to management and reported unit managers review all Progress Notes. LPN M reported R13 and R62 were separated because female resident was telling R13, no. LPN M reported neither R13 or R62 were their own responsible party. LPN M reported did not think at time R13 touching R62 was allegation of sexual abuse because R62 does not like anyone close or touching her and responded because of that. Review of the Nurse Progress Note, dated 4/6/2024 at 2:18 p.m., reflected, Resident behavior note: After lunch it was observed by housekeeping staff, resident self-propelled his wheelchair next to a female resident who was seated in front of the nurses station. He grabbed her leg and attempted to place his hand on her groin. Resident was removed from the area, staff requested resident stay away from the female residents. Female resident was very upset and told him to remove his hand. [Named R13] did not comply until staff intervened. Male resident was very upset and began yelling at the staff that he can do what he wants to do. Housekeeping notified CNA who continued to keep resident separated from female residents. Review of R13 Nurse Progress Note, dated 4/1/24, reflected, Res is on 15 min checks. Has wandered out of room x 3. Has not had clothes on and touching self in privates. Review of R13 Provider Note, dated 4/1/24, reflected, Staff note resident frequently takes all his close off. He mainly stay is in his room in this states, but has attempted to walk around facility. Review of R13 Nurse Progress Note, dated 3/23/24, reflected, .Staff reported there was a conversation between [named R13] and a female resident, [named R13] asked the female resident do you want to f*ck. Staff intervened and instructed male resident not to ask those questions because it is inappropriate. Female resident agreed and male resident said ok. Review of the Nurse Progress Note, dated 3/20/2024 at 4:24 a.m., reflected, Res noted walking around room with no bottoms on. Comes to door of room and is noted touching self and it is erect. Res states he likes to be naked at night he sleeps better. And states he is not going to stop exposing self. Review of R13 Behavior Monitoring Tasks, dated 3/20/24 through 4/18/24, reflected 11 occasions of sexually inappropriate behaviors, not including 4/6/24. During an interview on 4/17/24 at 2:16 PM, Nursing Home Administrator(NHA) A verified R13 did not have any Incident/Accident(I/A) reports in the past year. NHA A reported IA reports included all incidents not just falls. During an interview on 4/17/24 at 3:37 PM, Certified Nurse Aid(CNA) N reported R13 preferred to not wear cloths and had to frequently encourage R13 to put on cloths before exiting room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 4:00 PM, CNA O reported R13 was on 15 minute checks related to sexually inappropriate behaviors with female residents and was not own responsible person. CNA O reported R13 makes sexually inappropriate comments to both residents and staff. CNA O reported had not witnessed R13 touch a female resident, however, if it was witnessed CNA O reported would separate residents and report to nurse immediately because potential allegation of sexual abuse. During a telephone interview on 4/17/24 at 4:45 PM, Confidential Staff(CS) P reported R13 was on 15 minute checks for nudity, and aggressive behaviors. CS P reported behavior monitoring as difficult related to staffing concerns with three CNA staff and one nurse at times with eight 2 person assist residents on secure unit., and up to five residents that require 15 minute checks at one time. CS P reported example of sexual abuse allegation was unwanted touching. During record review on 4/18/24 at 9:45 AM, NHA A provided list of abuse allegations for past six months that did not include R13. During a confidential telephone interview on 4/18/24 at 10:31 AM, Confidential Staff (CS) Q reported heard R13 had sexually inappropriate behaviors including touching female residents inappropriately and that was one reason R13 was on 15 minute behavior checks. CS Q reported was present on 4/7/24 when CNA R caught R59 and R62 with hands down each others pants on couch in activity room of secure unit. CS Q reported LPN M was notified immediately who reported to management. CS Q reported if she would have witnessed situation would immediately separate residents, report immediately to nurse because allegation of sexual abuse. CS Q reported neither R59 or R62 were able to consent to sexual relations with diagnosis of advanced dementia. CS Q reported often three CNA staff and one nurse on secure unit day shift with several behaviors and impossible to monitor all residents at all times. CS Q reported when R59 and R62 were located on couch together staff were attempting to assist other residents to and from scheduled activities and no staff available to monitor residents in common area. CS Q reported activities are not engaging for residents on secure unit and would have less behaviors if more activities. Review of R59 Nursing Progress Note, dated 4/7/24, reflected, At approximately 1020 CNA notified CN that male resident and a female resident were in the activity (the end of the 500 hallway) room following an activity. When staff went in to remove male resident he was observed inappropriately touching himself. Staff immediately separated the residents and are continuing observation of both male and female resident. DON was notified via phone call at 1044. During a telephone interview on 4/18/24 at 11:26 AM, Housekeeping staff(HSK) S reported worked weekend of 4/6/24 and 4/7/24 and stated, staffing on weekends is crazy. HSK S reported often assisted on floors as able because just not enough staff available. HSK S reported on 4/6/24 on Oak hall had one CNA staff on each hall with one float CNA between halls along with one nurse. HSK S reported a resident fell in room and fractured neck while cna staff were assisting other residents and unable to assist injured resident timely. HSK S reported another resident in same room had change of condition and required transfer to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/18/24 at 11:55 AM, HSK T reported worked on 4/6/24 at the time of R13 and R62 incident. HSK T reported heard R62 yell, Don't touch me there. HSK T reported turned head and observed R13 near R62 located by Nurse station. HSK T reported HSK U observed the incident and reported to LPN M. HSK T reported if she would have witnessed would report to nurse because possible allegation of sexual abuse. HSK T reported was new employee and did not recall receiving abuse education. During an interview on 4/18/24 at 12:25 PM, HSK U reported had worked at the facility about 2 months and did not recall receiving abuse training from facility and was unable to name five types of abuse. HSK U reported was working on 4/6/24 and witnessed the resident to resident incident between R13 and R62 on the secure unite. HSK U reported was standing by shower room door located by Nurse Station and overheard R62 yell, don't touch me there. HSK U reported turned to look at both R13 and R62 located by the nurse station and observed R13 moving hand up R62's inner thigh to crotch area. HSK U reported turned to ask HSK T R13 name and as soon as R13 heard his name he moved away from R62. HSK U reported R62 was sitting in stationary chair and R13 was next to R62 sitting in wheelchair. HSK U reported knowledge of R13 history with preferences, including being naked in room and self pleasure behaviors and stated, that is why it caught my attention. HSK U reported overheard R13 say, did you like that? to R62 before R13 moved away from R62. During an interview on 4/18/24 at 1:00 PM, CNA G reported worked 4/7/24 did not witness R59 and R62 incident entered activity room, located at the end of the women's hall secure unit, after CNA R was attempting to separate R59 and R62. CNA G reported R59 and R62 were both on couch and CNA R reported R59 pants open with genital area exposed to R62. CNA G reported was reported to nurse because allegation of abuse. During a telephone interview on 4/18/24 at 1:15 PM, LPN M reported CNA R reported to her that R59 was inappropriately touching himself with genitals exposed to R62 while both sitting on couch in activity room on 4/7/24. LPN M reported incident immediately reported to the Director of Nursing(DON) B by telephone because allegation of sexual abuse. LPN M reported staff attempted to keep R59 off women's hall but was at the time of just before or just after activity and other staff assisting other residents. During a telephone interview on 4/18/24 at 1:44 PM, CNA R reported worked on 4/7/24 and witnessed incident between R59 and R62 in activity room. CNA R reported entered activity room and found R59 and R62 sitting on couch together. CNA R reported R59 had pants down with genitals exposed touching himself and R62 was staring at R59's genitals. CNA R reported immediately separated residents and redirected R59 from couch while R62 started yelling and became upset. CNA R reported incident to LPN M immediately because inappropriate behavior and called DON B. CNA R reported would be annoyed if either resident was her family and that behavior happened. CNA R reported three CNA staff and one nurse at that time and staff were assisting other residents on the unit at the time and no staff in activity room that that time. CNA R reported neither R59 or R62 were able to consent. Review of R13, R62 and R59 Electronic Medical Record, dated 4/6/24 through 4/16/24, reflected no evidence of social work follow up post 4/6/24 and 4/7/24 incidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 2:37 PM, DON B reported was responsible for staff schedules and used on shift system that used budget and facility census to staff facility. DON B reported goal for secure unit was one nurse and three to five CNA staff on day shift. DON B verified on 4/5/24, 4/6/24, and 4/7/24 the secure unit had one nurse and three CNA staff on day shift. DON B reported R59 and R62 were unable to consent and not their own responsible party. DON B reported did receive call from LPN M on 4/7/24 related to R59 and R62 incident and did not report to State of Michigan or Nursing Home Administrator(NHA) A because did not consider allegation of abuse related to information provided. DON B reported investigation was not completed. DON B reported allegation of sexual abuse would included non-consensual, unwanted touching. DON B reported was not aware of incident on 4/6/24 related to R13 and R62. During an interview on 4/18/24 at 3:45 PM, NHA A had been the facility Administrator for about 1.5 years, including abuse coordinator. NHA A reported would expect staff to notify NHA A immediately of all allegations of abuse if in building, and if not charge nurse then they would notify NHA immediately. NHA A reported initial investigation would then be started. NHA A reported she determines need for investigation after determining if intent through initial investigation. NHA A was queried, does it mater if intent or not related to residents with dementia? NHA A stated, depends. NHA A reported did not recall being informed of incident on 4/6/24 related to R13 and R62. NHA A reported recalled R13 on 15 minute checks related to inappropriate sexual comments and nudity. NHA A reported R13, R62 and R59 were not consenting adults and R62 had a very involved husband, with involved family who had recent discussion of providing R62 and husband private visits. NHA A reported unwanted intimate touch can be an example of sexual abuse. NHA A reported R13 and R62 inappropriate touching should have been reported to NHA A as allegation sexual abuse with need for investigation. NHA A reported aware R62 and R59 had history of believing one thinking the other was their spouse, however, no knowledge details related to 4/7/24 incident and reported should have been reported to the State Agency and investigation completed and was not done. NHA A reported would expect Social Work to follow up with all allegation of abuse for three days and document in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 46955 Based on observation, interview, and record review, the facility failed to ensure opened medications were appropriately labeled and that expired medications were disposed of in 2 of 3 medication carts reviewed for labeling and storage, resulting in the potential for decreased medication efficacy and adverse side effects. Findings include: On 4/17/24 at 8:00 AM, Oak Hall Medication Cart was reviewed in the presence of Registered Nurse/Unit Manager (RN/UM) D. During the review, an opened Lantus Solostar Insulin Pen with a pharmacy label reflecting R10's name was observed in the top left medication cart drawer. A separate label on the pen indicated, Date Opened_____Discard After 28 Days with no corresponding open date noted. RN/UM D confirmed that Lantus was an active medication for R10, that she did not know when it had been opened as lacked an open date and would be disposing of and getting a new one as had no way of knowing if the pen had been opened and used for more than the indicated 28 days. Review of R10's medical record revealed an active order, dated 12/14/2022, for Insulin Glargine (Lantus) with daily administration. Review of the corresponding Medication Administration Record (MAR) dated 4/1/24 - 4/30/24 reflected daily Lantus administration through 4/16/24. On 4/17/24 at 8:40 AM, Maple Hall Medication Cart was reviewed in the presence of Licensed Practical Nurse (LPN) F. During the review, an opened Fluticasone Propionate Inhaler with a pharmacy label reflecting R15's name on both the box and inhaler was noted with no open date indicated on either. LPN F confirmed that the inhaler was an active medication for R15, that she did not know when it had been opened as lacked an opened date, thought that it may be good for 60 days after opening, and would be disposing of and ordering a new. Review of R15's medical record revealed an active order, dated 1/4/24, for Fluticasone Propionate Inhaler with as needed administration for shortness of breath. Review of the corresponding MAR dated 4/1/24 - 4/30/24 reflected that the inhaler had been signed out as administered three times (4/11, 4/14, 4/16) for the current month. During the same medication cart review, an opened bottle of Latanoprost Ophthalmic Solution with a pharmacy label on both the box and bottle reflecting R3's name and a 2/12/24 dispense date was noted. Additionally, both the box and bottle contained a label with corresponding lines to indicate the open and expiration date of the eye drops with the lines on both noted to be blank. Printed instruction on the box indicated to discard 6 weeks after opening. LPN F confirmed that the eye drops were an active medication for R3, denied knowledge of when the eye drops were opened as confirmed that both the box and bottle lacked an open date and that as the eye drops were only good for 6 weeks after opening would be disposing of and ordering new ones as would be expired if opened on the indicated pharmacy dispense date of 2/12/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's medical record revealed an active order, dated 11/11/23, for Latanoprost Ophthalmic Solution with daily administration. Review of the corresponding MAR dated 4/1/24 - 4/30/24 reflected daily Latanoprost administration through 4/16/24. In an interview on 4/17/24 at 10:34 AM, Director of Nursing (DON) B stated that the pharmacy provided Medication Storage Guidance form was referenced to determine how long eye drops, inhalers, nasal sprays, and insulins were good for after opening as all had varying expiration dates based on the open date. Per DON B, the expectation was for all eye drops, inhalers, nasal sprays, and insulins to be labeled with an opened date by the assigned nurse upon initial use of the medication and that each nurse thereafter should check to ensure that the medication remained within the expiration date prior to subsequent administration. Review of the facility provided reference form dated 2023 and titled Medication Storage Guidance indicated for Latanoprost Ophthalmic Solution to .Date when opened and discard after 6 weeks . The Storage Recommendations for Injectable Diabetes Medications section of the same form indicated to dispose of a Lantus pen 28 days after opening. Review of the facility policy titled Medication Management with a 9/22/23 revised dated stated, Medications are stored, dispensed and destroyed in a manner to ensure safety and conformance with state and federal laws .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 48637 Based on observation, interview, and record review the facility failed to ensure proper label and dating of foods and documentation of food temperatures effecting 70 residents receiving meals from the kitchen resulting in increased the risk of contaminated foods and the risk of food borne illness. Findings include: During an initial tour of the kitchen on 4/16/2024 at 9:57 AM the following was observed in the reach in the freezer: 12 cups of strawberry shortcake ice cream in Styrofoam cups without a label and date During an initial tour of the kitchen on 4/16/2024 at 9:57 AM the following was observed in the reach in the refrigerator: 1 peanut butter and jelly sandwich in a plastic bag in a shallow pan with no date Approximately 20-8 oz cups of juice on a tray with no label and date During the initial tour, Dietary Manager (DM) H stated that the ice cream, peanut butter and jelly sandwich and juices should have labels and dates on them. On 4/17/2024 at 11:26 AM, during kitchen rounds, review of the time/temperature food preparation log from 4/2/2024 revealed that the temperature for coleslaw at the dinner meal was not recorded. Review of the time/temperature food preparation log from 4/6/2024 revealed that temperatures for the entire dinner meal was not recorded. During the kitchen rounds, DM H said that she wasn't sure why the temperatures weren't recorded and that they should have been completed. According to the 2017 FDA Food Code revealed: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Review of the Food Purchasing and Storage Policy with an origination date of 8/1/2011 and revision date of 11/11/2021 under procedures #5 Perishable Food Storage revealed, All food items in refrigerators will be properly dated, labeled, and placed in containers with lids, will be wrapped, or stored in sealed food storage bags. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Food Temperatures Policy with an origination date of 8/1/2011 and revision date of 11/12/2021 under procedures #4 revealed, Food temperatures will be taken and recorded for all TCS (Time/Temperature Control for Safety) foods at all meals. Record temperatures on food usage and temperature log sheets, which are part of the menu extensions and spreadsheets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235176	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Fremont	4554 W 48th St Fremont, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 48637 Based on observation and interview the facility failed to effectively maintain the outdoor dumpsters effecting 70 residents, resulting in the increased potential for odors and the attraction of pests and rodents. Findings include: On 4/17/2024 at 10:20 AM it was observed that 2 dumpsters, 1 trash dumpster and 1 cardboard boxes dumpster didn't have the lids closed. On 4/17/2024 at 1:32 PM, it was observed with Maintenance Assistant (MA) I that the same trash dumpster and cardboard boxes dumpster lids were not closed. MA I stated that the door to close the trash dumpster was stuck and he was not able to close the lid. MA I was able to close the cardboard boxes dumpster lid. On 4/17/2024 at 2:05 PM, Maintenance Director (MD) J stated that he wasn't aware that the trash dumpster lid didn't close until MA I told him. MD J said that MA I' told him that the frame was bent so he might have to call the dumpster company to come and fix it. When asked who makes sure the dumpster lids are shut, MD J said that anyone that uses it should shut it and stated, I close it a lot. On 4/17/2024 at 3:15 PM, MD J stated that he fixed the door on the trash dumpster so the lid was able to close now. During an interview on 4/18/2024 at approximately 4:00 PM, Nursing Home Administrator (NHA) A stated that she didn't have a policy regarding the outdoor dumpsters.