STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235733	A. Building B. Wing	02/12/2025

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

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49083 This citation pertains to intake #MI00150135. Based on interview and record review the facility failed to provide scheduled showers for one resident (R702) of three residents reviewed for activities of daily living, resulting in verbalized complaints and frustration with the provision of care. Findings include: On 2/12/25, a clinical record reviewed revealed R702 was admitted to the facility for rehabilitation and continued medical care on 1/17/25 after being hospitalized for a recurrent stroke which resulted in R702 having a new onset of ride sided weakness, aphasia (difficulty speaking), and bowel and bladder incontinence. Their medical history included: diabetes, uterine cancer, and left nephrectomy (removal of kidney). R702's Brief Interview for Mental Status (BIMS) scored totaled 15/15 indicating intact cognition. On 2/12/25 at 11:41 AM, an interview with Registered Nurse (RN) A confirmed residents are provided showers/bathing twice a week. RN A provided a white binder stored at the Nurses station that listed the shower schedules for their resident's and clarified schedules for bathing are based on their room number. Record review of the assignment grid revealed R702 was to be showered/bathed on Wednesdays and Saturdays on the afternoon shift. When asked if there was record of when residents are provided their showers/baths, RN A said showers were documented in the electronic medical record under the Certified Nursing Assistants (CNA) task. A review of the CNA task for showers/bathing was conducted and revealed R702 received only two showers since their admission on 1/17/25. On 2/12/25 at 12:30 PM, R702 and their spouse were interviewed. When asked how many times they were provided a shower, R702 recalled only once or twice, to which their spouse agreed. On 2/12/25 at 2:15 PM, the Director of Nursing (DON) was asked how many times residents are to be showered/bathed and the DON reported two times a week. The DON acknowledged the concern when provided documentation of R702 only provided two showers since admission on 1/17/25. Review of the Facility Policy titled; Routine Resident Care, dated 3/2023. Documented: (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Residents receive the necessary assistance to maintain good grooming and personal hygiene .Showers, tub baths, and/or shampoos are scheduled according to person center care .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00149847 Based on observation, interview, and record review, the facility failed to ensure physician ordered dressing changes for pressure ulcers were performed for one resident (R701) of three residents reviewed for pressure ulcers, resulting in the potential for worsening of wounds and development of infections. Findings include: On 2/12/25 at 8:51 AM, R701 was observed in their bed with their eyes closed. R701 had kerlix (dressing wrap) on their bilateral lower extremities. On 2/12/25 at 9:32 AM, a review of R701's clinical record revealed they readmitted to the facility on [DATE]. Their diagnoses included: osteomyelitis (bone infection), sepsis, protein calorie malnutrition, failure to thrive, neuromuscular dysfunction of the bladder, quadriplegia, presence of a feeding tube, urinary catheter, and colostomy. Continued review of the record included a wound care note dated 2/11/24 that indicated they had multiple pressure ulcers including a sacrum, right hip, and right calf stage IV (full-thickness skin loss that exposes muscle, bone, or other tissue) as well as a left calf and left heel unstageable (a full-thickness skin loss where the base of the wound is covered by slough or eschar) ulcer. R701's wound care orders included treatments to the ulcers scheduled every day and night shift. On 2/12/25 at approximately 11:15 AM, an observation of R701's dressings was conducted with Nurse 'B' and Unit Manager 'C'. The dressings were observed to be dated 2/11/25, however; there was no shift time observed on the dressings and the dressing to their sacrum appeared shadowed with wound drainage. A review of R701's TAR (treatment administration record) was conducted and revealed the following: treatments scheduled for the day and night shift for the left heel, left calf, right calf, and sacrum were not documented as completed on 2/8/25 day shift, 2/9/25 night shift, and 2/11/25 night shift. The treatment on 2/6/25 night shift was coded as a '5' referring to a nursing note, however; no accompanying note was in the record to indicate why the treatments were not performed. On 2/12/25 at 11:32 AM, an interview was conducted with the facility's Director of Nursing. They indicated the treatments should be performed per physician's orders and the facility's Wound Care Nurse was responsible for ensuring they were done. A review of a policy titled, Skin Management revised 8/2024 was conducted and read, .Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00149847. Based on observation, interview, and record review, the facility failed to ensure appropriate transmission based precautions were implemented for one resident, (R701) of three residents revealed for infections, resulting in the potential for the development of infection. Findings include: On 2/12/25 at 8:50 AM, R701's room was observed. The door of the room did not contain any signage to indicate they were on any TBP (transmission based precautions), nor were there any PPE (personal protective equipment) supplies (gowns, gloves, masks, etc.) outside or in the vicinity of the room. On 2/12/25 at 8:51 AM, R701 was observed in their bed with their eyes closed. A tube feeding pump delivering tube feeding formula, a urinary catheter drainage bag hung on the left side of the bed, and an intravenous infusion of antibiotics being delivered via PICC (peripherally inserted central catheter) line were observed. On 2/12/25 at 9:32 AM, a review of R701's clinical record revealed they readmitted to the facility on [DATE]. Their diagnoses included: osteomyelitis (bone infection), sepsis, protein calorie malnutrition, failure to thrive, neuromuscular dysfunction of the bladder, quadriplegia, presence of a feeding tube, urinary catheter, and colostomy. Continued review of the record included a wound care note dated 2/11/24 that indicated they had multiple pressure ulcers including a sacrum, right hip, and right calf stage IV (full-thickness skin loss that exposes muscle, bone, or other tissue) as well as a left calf and left heel unstageable (a full-thickness skin loss where the base of the wound is covered by slough or eschar) ulcer. R701's physician's orders revealed multiple intravenous antibiotic orders as well as an order for enhanced barrier precautions (an infection control strategy where healthcare workers wear gowns and gloves during high-contact resident care activities) related to a history of multiple drug resistant organisms, wounds, feeding tube, urinary catheter, and PICC line. On 2/12/25 at 11:02 AM, Nurse 'B' was observed administering medications via R701's feeding tube wearing a pair of examination gloves and no gown. At approximately 11:15 AM, Unit Manager 'C' entered the room, and with Nurse 'B' R701 they repositioned R701 for an observation of the dressings to their calves, heels, and sacrum. Nurse 'A' and Unit manager 'C' were observed to be wearing examination gloves but no gown during the repositioning and assessment. On 2/12/25 at 11:32 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding R701 and they indicated R701 should have been on enhanced barrier precautions and staff should wear the appropriate PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided policy titled, Enhanced Barrier Precautions (EBP) was conducted and read, It is the intent of this facility to use Enhanced Barrier Precautions (EBP) in addition to Standard Precautions for prevention the transmission of CDC targeted multidrug-resistant organisms (MDROs). Enhanced Barrier Precautions are indicated for residents with any of the following: .a wound or indwelling medical device . chronic wounds generally include, but are not limited to, chronic wounds such as pressure ulcer .Indwelling medical devices include central lines, urinary catheter, feeding tubes . Implementation .Post signage for precautions on the door or wall outside of the resident's room Health care personnel caring for residents on Enhanced Precautions should wear gloves and gowns during high-contact resident care .