STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235333	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency, A Villa Center	12575 S Telegraph Rd Taylor, MI 48180

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to Intake MI00139649. Based on interview and record review, the facility failed to ensure appropriate transfer documentation was in place for one resident (R607) out of one resident reviewed for hospital transfer, resulting in the lack of information regarding resident's health status, safety, and transfer arrangements upon transfer from the facility. Findings include: A review of the Admission Record for Resident #607 (R607) documented an admitted [DATE]. R607 was discharged from the facility on 11/9/23. R607's diagnoses included congestive heart failure, opioid dependence, atrial fibrillation, and depressive disorder. A Minimum Data Set assessment dated [DATE] documented intact cognition. An interview and record review were conducted with the Director of Nursing (DON) on 4/4/24 at 11:19 AM. The DON said R607 went to the hospital for hip surgery and did not return. An eMAR (Electronic Medication Administration Record) note of 11/9/23 at 1:05 PM documented R607 went out for surgery. The DON said there should be a discharge progress note which indicated where the resident went, how they were transported, and the resident's condition upon transfer. This information was needed for continuity of care for the facility, the resident's doctor, and the responsible party. The nurse on duty should have documented a discharge note. A review of a document in R607's clinical record titled, Functional Abilities and Goals - Discharge, dated 11/11/23, did not indicate where the resident was sent, disposition upon leaving, or how the resident was transported. A review of the facility document titled, Transfer and Discharge Guideline, dated 11/28/17, revealed in part the following: - When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. - Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1) (i) of this section. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 3:50 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to Intake MI00141041. Based on interview and record review, the facility failed to demonstrate professional standards of practice by not consistently obtaining resident's blood pressure readings prior to the administration of anti-hypertensive medications as ordered for one resident (R608) out of three residents reviewed for physician's orders, resulting in the potential for hypotension. Findings include: It was reported to the State Agency that a resident was receiving medication without proper monitoring. A review of the Admission Record for Resident #608 (R608) documented an admitted [DATE]. R608 was discharged from the facility on 10/31/23. R608's diagnoses included chronic obstructive pulmonary disease, hypertension, hypertensive heart disease without heart failure, and atherosclerotic heart disease of native coronary artery without angina pectoris. A Minimum Data Set assessment dated [DATE] documented intact cognition. A review of physician's orders documented that R608 was prescribed the following medications that required monitoring of R608's blood pressure, and the medications were to be held if the resident's systolic blood pressure (the first number when blood pressure was measured) was less than 100: 1. Nifedipine 60 mg tablet at 9:00 AM. Hold for SBP (systolic blood pressure) less than 100. 2. Carvedilol 25 mg tablet at 9:00 AM and 9:00 PM. Hold for SBP less than 110 or HR (heart rate) less than 60. 3. Hydralazine 100 mg tablet at 5:00 AM, 1:00 PM, and 9:00 PM. Hold for SBP less than 100. On 4/4/24 at 11:40 AM an interview and record review were conducted with the Director of Nursing (DON). A review of the vital signs obtained on R608 during the months of September 2023 and October 2023 documented that a 5:00 AM blood pressure was only obtained on 9/2/23, 9/22/23, 10/8/23, 10/9/23, and 10/26/23 and a 1:00 PM blood pressure was obtained on 9/15/23. The DON acknowledged that R608 did not have his blood pressure obtained according to physician's orders. The DON said that typically a physician wants a blood pressure taken prior to administration of an antihypertensive medication to be sure that when the blood pressure medication was administered that the blood pressure was not too low and then the resident bottoms out. The DON stated, The nurse should have taken and documented the blood pressure prior to administration. On 4/4/24 at 3:50 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to Intake MI00141603. Based on interview and record review, the facility failed to adequately complete discharge instructions and recapitulation of stay in a timely manner for one resident (R611) of three residents reviewed for a comprehensive discharge summary, resulting in the potential for lack of communication to care providers assuming the resident's care. Findings include: It was reported to the State Agency that the facility did not adequately help resident with a discharge from the facility. A review of the Admission Record for Resident #611 (R611) revealed an admitted [DATE]. R611 was discharged home from the facility on 12/22/23. R611's diagnoses included hypertensive urgency and cervical disc disorder with myelopathy. A Minimum Data Set assessment dated [DATE] documented intact cognition. During an interview and review of R611's clinical record with the Director of Nursing (DON) on 4/4/24 at 12:02 PM, a document titled, Recapitulation of Stay [Discharge Summary], dated 12/22/23, revealed the following. The Summary of Stay on this document was blank. No information was provided for the following: 1. Select Diagnosis; 2. Further description of diagnosis/condition; 3. Pertinent current lab values; 4. Pertinent on-going labs needed; 5. Other/future diagnostic tests and results; 6. Documented consultations; 7. Other pertinent information for continuing care and/or special instructions or precautions for continuing care; 8. Practitioner contact information; 9. Comprehensive care plan goals; and 10. Resident consents to release of this summary to next care giver. The DON said the recapitulation of stay was not adequately completed, and the recap of stay helps with continuity of care. The completion of the recap of stay was to be a collaborative effort usually completed by nursing and social work. A review of the facility document titled, Discharge Summary - Recapitulation of Resident Stay Guideline, dated 11/28/17, revealed in part the following: It is the practice of this facility that residents who have a planned discharge from the facility will have a completed discharge plan and recapitulation of stay completed to facilitate continuity of care after discharge. On 4/4/24 at 3:50 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46865 This citation pertains to intake MI00141883 and MI00141437. Based on interview and record review the facility failed to consistently conduct weekly skin observations for two residents (R606 and R610) and a Braden skin assessment for one resident (R610) of three residents reviewed for maintenance of skin integrity, resulting in the potential for skin care needs to go undetected. Findings include: R606 A review of R606's EMR (Electronic Medical Record) revealed R606 was admitted to the facility on [DATE] and discharged from the facility on 12/20/23. According to R606's EMR, R606 had the following medical diagnoses: Cutaneous Abscess of the Buttock, Generalized Muscle Weakness, need for assistance with personal care, and moderate protein-calorie malnutrition. A review of R606's MDS (Minimum Data Set), dated 11/25/23, revealed R606 had a BIMS (Brief Interview of Mental Status) score of 9/15 (moderate cognitive impairment). According to the MDS, R606 required maximal assistance with bed mobility, transfers, and toileting. A review of R606's skin integrity care plan, with no date, revealed, Monitor skin when providing care, notify nurse of any changes in skin appearance. A review of R606's documentation in the EMR for weekly skin observations revealed that R606 had not received any weekly skin observations after 10/29/23 until the discharge date of [DATE]. On 4/4/24 at 10:44 AM the Director of Nursing (DON) was interviewed regarding the lack of documentation of weekly skin assessments. The DON verified that there was no documentation of weekly skin observations in R606's EMR after 10/29/23. The DON said it was expected that the nursing staff follow the guidelines of weekly skin assessments. 34901 R610 A review of the Admission Record for Resident #610 (R610) documented an admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease, protein-calorie malnutrition, cachexia, colostomy status, and contracture of unspecified joint. A MDS assessment dated [DATE] documented intact cognition and no present pressure ulcer but resident was at risk for pressure ulcer development. A document titled, Functional Abilities and Goals, dated 2/29/24 documented R610 was dependent upon staff for mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document titled, Braden Scale for Predicting Pressure Sore Risk, dated 12/24/2023, documented R610 was a high risk for developing a pressure sore. The assessment of R610's risk for pressure ulcer development was to be completed quarterly. On 4/4/24 at 11:52 AM, an interview and record review were conducted with the DON. The DON stated that R610 has dermatitis in the genital region, an abrasion to the right knee, and resolved pressure ulcer to the sacrum, surgical wound to abdomen, and MASD (moisture-associated skin damage) to lower back. The last available skin evaluation completed on R610 was 2/4/24. The March 2024 Medication Administration Record documented weekly skin checks were completed, however completed skin evaluations were not available for review in the electronic health record. The DON stated, It is checked off on the MAR that it was done, but there is nothing in the (EHR) to give us details. The DON added that the purpose of a weekly skin evaluation was to ensure that there are no new identified issues with (the resident's) skin integrity. The DON confirmed that the completion of R610's next quarterly risk assessment for pressure ulcer development was overdue. A facility document titled, Skin Management Guideline, dated 11/28/17, revealed in part the following: - To ensure residents that are admitted to the facility are evaluated to determine appropriate measure to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown. - It is the practice of this facility to properly identify and evaluate residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcer; to implement preventative measure; and to provide appropriate treatment modalities for wounds according to industry standards of care. On 4/4/24 at 3:50 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46865 Based on observation, interview, and record review, the facility failed to perform proper sterile hygiene practices, hand hygiene, and glove usage for one resident (R624) of two residents reviewed for tracheostomy care, resulting in the potential for tracheostomy infection and airway impairment. Findings include: On 4/4/24 at 9:35 AM an observation was made of LPN (Licensed Practical Nurse) G providing tracheostomy care on R624. LPN G sanitized his hands when entering the room. LPN G put a PPE (Personal Protective Equipment) gown on. LPN G put on gloves and a face shield. Then LPN G closed R624's curtain for privacy. LPN G gathered tracheostomy supplies and placed them on the bedside table. LPN G opened the tracheostomy kit. LPN G took out the basin that was inside the kit. LPN G removed and discarded both gloves. LPN G then donned a sterile left-hand glove. The right-hand sterile glove fell on the bedside table prior to LPN G donning it. Then LPN G placed the sterile field on to the bedside table. LPN G opened the normal saline solution with his left hand and poured the solution into the basin. LPN G took off R624's tracheostomy dressing with his left hand. LPN G removed the used cannula with the left hand. LPN G picked up a sterile cannula with the right hand and placed it into R624's tracheostomy opening. LPN G suctioned secretions from R624's tracheostomy. LPN G doffed his gloves. LPN G donned clean gloves, replaced R624's tracheostomy ties, and replaced R624's tracheostomy oxygen mask. LPN G suctioned secretions from R624's tracheostomy again. LPN G doffed his gloves. LPN G discarded used items from the procedure. LPN G exited R624's room and sanitized his hands. On 4/4/24 at 10:11 AM LPN G was interviewed regarding the procedure of providing tracheostomy care and performing proper hygiene practices. LPN G acknowledge that he did not follow proper sterile technique when donning gloves, and that he did not perform proper hand hygiene when switching gloves. Also, LPN G acknowledged that he did not take off his gloves when they were considered dirty throughout the procedure. On 4/4/24 at 11:00 AM the DON (Director of Nursing) was interviewed about the standard hygiene practices of tracheostomy care and her expectation when performing tracheostomy care. The DON said tracheostomy care was a sterile procedure, and the nursing staff should maintain sterile technique. A review of R624's EMR (Electronic Medical Record) revealed R624 was admitted to the facility 3/1/24. According to the EMR, R624 had the following medical diagnoses: Quadriplegia, Anoxic Brain Damage, and Tracheostomy. A review of R624's MDS (Minimum Data Set) dated 3/11/24 revealed R624 was unable to complete the BIMS (Brief Interview of Mental Status) screening. According to the MDS, R624 was dependent upon assistance for oral hygiene and personal hygiene. A review of R624's tracheostomy care plan, with no date, revealed the following: Use Universal Precautions as appropriate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a policy provided by the facility during the survey titled, (Industry Name) Respiratory Therapy Guideline Tracheostomy Care/Tube Change in Both Elective or Emergency Situations, revealed the following: Wash hands-follow hand hygiene procedure. A review of the facility policy, Hand Hygiene Guideline, with an effective date of 11/28/17, revealed the following: Gloves .are not a substitute for hand hygiene.