| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235333 | A. Building<br>B. Wing | 08/27/2024 |

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

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 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208<br><br>This citation pertains to intake #'s MI00146301 and MI00146393.<br><br>Based on observation, interview, and record review, the facility failed to ensure accurate assessments and implementation of indwelling urinary catheter care for two residents, (R901 and R902) of three residents reviewed for urinary catheters, resulting in the potential for the development of urinary tract infections and complications from indwelling urinary catheters.<br><br>Findings include:<br><br>R901<br><br>On 8/27/24 at 10:50 AM, R901 was observed in their bed asleep. A urinary catheter drainage bag was observed clipped to the left side of the bed. The urine in the catheter tubing and drainage bag was clear and dark yellow in color.<br><br>A review of R901's clinical record revealed they admitted to the facility on [DATE], discharged to the emergency roiagnom on [DATE], and readmitted on [DATE]. R901's diagnoses included: Parkinson's Disease, urinary tract infection (UTI), obstructive reflux uropathy, urinary retention, intestinal hemorrhage, heart failure, and seizures. An admission Minimum Data Set assessment dated [DATE] revealed R901 had moderately impaired cognition and admitted to the facility with an indwelling urinary catheter.<br><br>A review of R901's admission assessments revealed a Nursing Evaluation V (version) 8 dated 6/3/24 indicating they admitted to the facility with a urinary catheter. An additional assessment, Bladder Evaluation V 3 dated 6/3/24 also revealed staff knowledge of R901 admitting to the facility with a urinary catheter.<br><br>A review of R901's physician's orders and medication administration record (MAR) was conducted and revealed orders for urinary catheter care, orders to empty the urinary drainage bag and document the output, and orders to change the catheter were first implemented on 6/12/24, despite R901 admitting to the facility on [DATE] with a urinary catheter.<br><br>R902<br><br>(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 |
|---|---|---|

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/27/24 at 11:00 AM, an interview was conducted with R902. They were asked about their urinary catheter and said they had the catheter placed in the emergency room and admitted to the facility with it. They were asked if the facility provided catheter care and said they did not when they first admitted but they were now. They further reported they had to go the hospital shortly after their admission when a surgical drain tube came out and said while in the hospital they were treated for a UTI. A review of R902's hospital records scanned into the electronic medical record for their admission to the hospital was conducted, however; the records did not include any information regarding treatment for a UTI.<br><br>A review of R902's clinical record revealed they admitted to the facility on [DATE] with diagnoses including: lumbar discitis, lumbar osteomyelitis, diabetes, pressure ulcers, and heart failure. A review of R902's nursing admission assessments and progress notes was conducted and revealed no evidence of the presence of a urinary catheter. Continued review of R902's record revealed the first documented evidence of the catheter was documented by NP 'E' on 6/3/24. A review of R902's physician's orders and MAR was conducted and revealed no orders for urinary catheter care, orders to empty the urinary drainage bag and document the output, or orders to change the catheter were implemented on admission. The record further revealed R902 transferred to the hospital on 6/7/24, readmitted to the facility on [DATE], and between the two admissions the first orders for catheter care were noted to be placed and documented on 6/23/24.<br><br>An interview with the facility's Director of Nursing (DON) was conducted on 8/27/24 at 10:28 AM. The DON explained they were aware of the concerns surrounding assessments, placing orders, and documenting urinary catheter care. At that time, they provided multiple documents to demonstrate their efforts on a past non-compliance.<br><br>A review of a facility provided document titled, Urinary Indwelling Catheter Management Guideline effective 11/28/17 was reviewed and read, .Completion of a Bladder Observation will be completed upon admission . Additional care practices should include: .Recognizing and evaluating for complications .Every shift evaluation, during cares, of urine appearance for changes .<br><br>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: identification of affected and like individuals, completed assessments, updated assessments, obtaining physician's orders for catheter related care, updated certified nursing aide care guides, addition of catheter related tasks for the certified nurse aides, updated care plans, nursing education, and ongoing auditing for compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance. |