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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency, A Villa Center	12575 S Telegraph Rd 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 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** 22349 Based on observation, interview, and record review, the facility failed to implement physician orders for one (R603) of four residents reviewed for falls, resulting in R603 not receiving a topical pain medication or having a urinalysis (laboratory test used to detect urinary tract infections) completed. Findings include: On 3/18/25 at 10:36 AM, R603 was observed in the dining room seated in a wheelchair with a purple discoloration surrounding the left eye and upper left cheek bone area. R603 was interviewed and could not recall how they obtained the black eye. R603 denied having any pain. Certified Nursing Assistant (CNA) I was present and said the resident had a fall, about a week ago. According to R603's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included Parkinson's disease and Alzheimer's disease. The Minimum Data Set (MDS) dated [DATE] indicated R603 had severely impaired cognition status with a Brief Interview for Mental Status (BIMS) score of 4/15. A progress note dated 3/1/25 at 2:30 PM indicated R603 fell out of the wheelchair and hit their head on the floor when another resident pushed R603's wheelchair out of the way in an attempt to move past the resident in the dining room. R603 was assessed and denied pain. No injuries were observed at that time and the resident was assisted back into the wheelchair. Nurse Practitioner (NP) B was notified and ordered the following; urinalysis, blood draw for CMP (complete metabolic panel) and CBC (complete blood count). The resident was sent to the hospital for CT scan of head (Computed Tomography Scan- cross sectional X-ray). A review of R603's hospital records dated 3/1/25, revealed the resident's CT scan of the head was negative. The resident had CMP and CBC results, but no urinalysis was completed. The resident was returned to the facility with new orders for Lidocaine 4 % topical pain patch every 12 hours for 5 days. (continued on next page)

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
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R603's re-admission orders or 3/1/25 did not transcribe the order for the Lidocaine 4% topical pain patch every 12 hours for 5 days. R603's Medication Administration Record (MAR) did not include the Lidocaine 4% topical pain patch as a medication to be administered. There were no progress notes on 3/1/25 to indicate the Lidocaine 4% patch was ordered. There was no documentation or results to indicate the resident had a urinalysis completed. The MAR had documented pain assessments every shift that indicated the resident had denied pain. On 3/19/25 at approximately 10:00 AM Licensed Practical Nurse (LPN) A and the Director of Nursing (DON) reviewed R603's EHR and confirmed that the resident's order for Lidocaine 4% topical pain patch had not been transcribed or administered to the resident. The DON said, I don't know how this got missed. When a resident returns from the hospital we should review the summary visit and call the physician to clarify orders. It looks like we did not do this. LPN A reviewed the EHR and said, I don't know why we did not complete the urinalysis. I thought maybe they did it at the hospital, but it was not done there either. On 3/19/25 at approximately 11:00 AM, NP B acknowledged that R603 did not receive the Lidocaine 4% topical pain patch after the fall on 3/1/25 as prescribed by the hospital physician. I don't remember getting called when they (R603) returned to the facility. I would have agreed with that order. It should have been on the MAR. I did order the resident to have urinalysis. I don't know why that did not get done.