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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235479	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Livonia	14900 Middlebelt Road Livonia, MI 48154

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 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to the Complaint Intake # 272114.Based on observation, interview and record review the facility failed to ensure proper diagnosis or clinical indication to support the insertion of an indwelling catheter for three (3) residents: Resident #501 (R501), Resident #502 (R502), and Resident #504 (R504) of 4 residents reviewed for indwelling catheter resulting in improper catheter management leading to a potential recurrent catheter-associated urinary tract infection (CAUTI), sepsis and hospitalization.Findings include:Resident #501: (R501) On 1/27/26 at 12:40 PM, R501 was observed in her room lying in bed, alert and oriented. R501 expressed concerns about her catheter care. She had an indwelling catheter in place with clear-to-light-yellow urine output. The catheter tubing was patent and connected to a privacy drain bag. No signs of cloudiness, bleeding, or foul odor were observed.During an interview with R501 on 1/27/26 at 12:40 PM, she did not know why she had complained about a recent incident related to her indwelling catheter. R501 stated: Something went wrong with it, and they couldn't fix it. I felt I needed to be transferred to the hospital, but the staff refused to call 911. R501 reported that the staff did not allow her to go to the hospital. They said they needed the physician's permission to approve the transfer. R501emphasized that she has not seen the physician at all during her entire stay at the facility. R501 called her daughter to call 911. R501 expressed being upset because she was her own person and felt her rights were violated, and was kept against her wishes. A review of R501's clinical record was conducted on 1/27/26 at 12:40 PM. R501 was [AGE] years old and was admitted to the facility on 9//25/2025. According to her Brief Interview of Mental Status (BIMS) Score with an assessment dated [DATE], R501 scored 15/15. A score of 15 means that R501 was cognitively intact. R501's list of diagnoses was reviewed. R501 did not indicate any Urinary retention or difficulty in urination to support the indwelling catheter placement. However, R501 had laboratory results on 12/10/25 and another on 1/13/26, diagnosed with Urinary Tract Infection, and received an order for antibiotic therapy. On 1/27/26 at approximately 1:32 PM, the Director of Nursing (DON) was interviewed regarding R501's indwelling catheter and the reason for its placement. The DON admitted that R501 has urinary retention but was not recorded in the list of diagnoses. R501 goes to her urologist, and the staff must have missed putting the diagnosis in R501's list of diagnoses. She asked to leave the room to review the resident's clinical record. A few minutes later, the DON returned and told the surveyor that a diagnosis had been added to the R501 record. On 1/27/26, an unidentified nursing staff member created a new entry in the electronic medical record for R501 (the nursing staff member was not listed on the facility-provided staff list). Date created: 1/27/26; new diagnosis code: R33.9; description: Retention of Urine, unspecified.The DON explained on 1/27/26 at 1:35 PM that the diagnosis was found in the urology consult notes dated 1/11/26. She confirmed that they just entered the diagnosis of urinary retention today. Further review of R501's clinical record was conducted on 1/27/26 at (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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:00 PM. R501 was dependent on staff in toileting hygiene: the ability to maintain perineal hygiene and to adjust clothes before and after voiding or after a bowel movement. She is also dependent during showers/bath, including washing, rinsing, and drying herself. R501 required Substantial/Maximal assistance from staff with most activities of daily living ADL however remained totally dependent with movements from side to side in bed and transfers in the Minimum Data Set (MDS) assessment dated [DATE]. R501 was non-ambulatory according to the MDS assessment under the section GG conducted on 1/16/26. Section H of the MDS revealed that an indwelling catheter was in place during the 1/17/26 assessment. R501 was always incontinent with her bowel movement. A review of R501's clinical laboratory results dated [DATE], revealed a positive for Urinary tract infection. An order for an antibiotic (Amoxicillin-Pot Clavulanate) 825/125 mg, 1 tablet every 12 hours, was ordered for Urinary Tract Infection (UTI) for 7 days. According to the R501's Medication Administration Record (MAR)dated December 2025, R501 received only 3 dosages from 12/10 to 12/11 and was transferred to the hospital on [DATE] and returned on 12/18/2025.On January 13, 2025, Laboratory results confirmed a UTI. An order for Augmentin (an antibiotic) dated 1/12/2026 was noted: a leaking Foley and concerns for UTI, as noted in the clinical observation notes, with other symptoms of dark brown urine and increased sediment. R501 was Afebrile (no fever).According to R501's MAR dated January 2026, R501 received two separate antibiotic therapies: one ordered on 1/12/26 to 1/17/26 (5 days) and another ordered on 1/21/26, which was completed on 1/27/26. Resident #502(R502) R502 was observed with an indwelling catheter on 1/27/2026 at 12:22 PM. R502 was with her son at the bedside. During the interview, R502's son, who is the POA (Power of Attorney), expressed that R502 just recently had a UTI from her catheter and was on antibiotics. Although R502 did not have any concerns regarding the catheter, she did have concerns about the wait when she needed care. It takes a while. R502 stated she does have wounds and was worried about getting them infected if she gets soiled and unattended for prolonged periods. On 1/27/26, R502's indwelling catheter tubing was observed patent with yellow colored urine and no abnormal discoloration or blood in urine. R502 was ask by the surveyor why she has the catheter and when did she have them? She shrugged her shoulder and did not give a definite answer. A review of R502's list of diagnoses in the clinical record shows no diagnosis that indicates the reason for the placement of an indwelling catheter. An order dated 12/17/25 to change Foley as needed and to secure the Foley catheter tubing with a secure strap. Check placement q shift. Replace as needed. Date ordered on 12/17/25. R502 was [AGE] years old and admitted to the facility on [DATE] with the primary diagnosis of Paroxysmal Atrial Fibrillation, Hypothyroidism, Type 2 diabetes mellitus, and Essential hypertension in addition to other diagnoses. On 1/27/26 at 2:00 PM, during the review of R502's clinical record, there was no diagnosis related to retention of urine, bladder obstruction, or any neurologic bladder anomaly. R502's care plan was created upon admission on [DATE], indicating that R502 had an indwelling catheter requiring catheter care. No urinary retention or neurologic problems indicating urinary retention or obstruction were listed in the facility's record in R502's Diagnosis list. There were no wounds in R502's list of diagnoses in the clinical record. Urine laboratory testing dated 1/13/26 confirmed a Urinary tract infection with multiple organisms, including Candida albicans, Klebsiella, and E. coli, among others.A review of R502's Medication Administration Record indicated that an antibiotic therapy, Amoxicillin-pot clavulanate 875-125 mg 1 tab every 12 hours for 10 days, which started on 1/14/26 and ended on 1/23/26. A new order entry for Foley catheter care every shift, starting on 1/23/26, was noted in the MAR. R502 had an indwelling catheter since admission on [DATE]. On 1/27/26 at approximately 1:32 PM, the Director of Nursing (DON) was interviewed regarding R502's indwelling catheter and the indication for its placement. The DON agreed that R50's list of diagnoses (continued on next page)

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