

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Regency at Livonia		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** This citation pertains to intake #3094316Based on observation, interview and record review, the facility failed to monitor blood glucose levels and follow hospital discharge medication (insulin) orders for one resident (R700) of three reviewed for medication orders. Findings include:A review of R700's medical record revealed a progress note dated 7/2/26, Observed resident with clammy skin and not able to talk but responding to verbal stimuli by looking at writer when talking. BS (Blood Sugar) taken and reading was HI (indicating elevated BS level). NP (Nurse Practitioner) notified and ordered 10 units of Novolog (rapid acting insulin) to be given. Writer waited 20 minutes and the reading was still indicating HI. NP notified and gave orders to give 8 units of Novolog, and the residents blood sugar still remained HI. Medical Doctor in building went to see resident and ordered their transfer to hospital. Unit Manager, Nurse Practitioner, Director of Nursing, (DON) and daughter notified of resident's status.A facility medical record review revealed, R700 was admitted to the facility on [DATE] with diagnoses including Type I Diabetes Mellitus with Hyperglycemia, Hyperthyroidism, and Atrial Fibrillation. A review of the hospital after summary visit (ASV-discharge orders) dated 6/30/2026 for R700 revealed the following: Continue insulin Lispro (rapid acting insulin) 100 unit/ML (millimeter) patient supplied (insulin) pump. (Lispro insulin) Commonly known as Humalog. One each by continuous sub -Q (cutaneous) infusion (via wearable injector) route continuously.Further review of R700's medical record revealed a nursing note dated 6/30/26 at 8:00 AM, documenting, Treatment: Continue medications as per AVS (after visit summary), rounding provider to f/u (follow up). Patient medications were reviewed/verified against discharge summary which nursing had supplied. On 7/31/26 at 11:57 PM, Licensed Practical Nurse (LPN) A was queried regarding R700's insulin and blood sugar monitoring orders from the hospital and explained R700 was admitted with an order to continue insulin Lispro (rapid acting insulin) 100 unit/ML (millimeter) patient supplied (insulin) pump. LPN A confirmed they did not add blood sugar monitoring when transcribing the orders and because the resident had an insulin pump at home, and the orders should have been changed to manage the resident's insulin per facility protocol. On 7/31/2026 at 1:26 PM, an interview was completed with the DON who stated, The facility usually 'catches' orders of pumps, and insulin orders are changed to being monitored daily. This was not caught upon admission.A review of the facility policy titled, Diabetic Management dated 3/1/2013 and revised on 9/22/2023 revealed the following: Diabetic management involves both preventative measures and treatment of complications. Upon admission, the interdisciplinary team works together to implement a plan of care to minimize complications. Upon admission the interdisciplinary team evaluates the diabetic resident and implements a plan of care to ensure: Orders are received and are accurate related to blood glucose monitoring and anti-diabetic agents. Blood glucose orders should include parameters to follow and when to notify the physician; Appropriate nutritional orders are in place; and Preventative skin care measures are in places.During (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: Both staff were interviewed, the Acting DON re-educated both staff on transcribing the medication orders from the After Visit Summary, obtaining an order from the physician regarding blood sugar monitoring and how often and doing a thorough skin assessment and validating the pump was actually at the facility along with the actual medication. How facility identified resident(s) affected and residents with the potential to be affected by the same deficient practice. Reviewed the newly admitted residents transcribed medication orders from the After Visit Summary. Measures or systemic changes made to ensure that deficient practice will not occur and affect others: The facility immediately reviewed recent admitted residents' transcribed orders from the After Visit Summary. Nursing staff were re-educated on transcribing the medication orders from the After Visit Summary. How facility monitors its corrective actions to ensure deficient practice was corrected and not recur. The DON / Designee will review new admitted residents transcribed medication orders from the After Visit Summary. Any concerns will be addressed immediately, and the finding will be reported to the QAPI (Quality Assurance Process Improvement) committee for further recommendations. Date of compliance 7/14/26 The facility was able to demonstrate monitoring of the corrective action and maintained compliance as confirmed onsite.		