STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235333	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation referrs to Intake number MI 7. Based on observation, interview and record review the facility failed to consistenly document bath/shower sheets and provided proper grooming for one sampled resident (R#703) of three sampled residents reviewed for activites of daily living (ADL's) resulting in poor grooming, hygeine and body odor. Findings include: Complaint reported to State Agency that R#703 was not being provided showers regularly. On 6/23/20 at 11:45 am, R#703 was observed laying in bed. The linen at the foot of the bed was soiled with yellowish, brown stains. The banadge on the right heel was soaked with brownish drainage. The resident appeared obese. Food debris was observed on the resident's gown. A body odor was noted. R#703's hair appeared greasy, and facial hair noted. R#703 was asked when the last time he had received a shower or bed bath to which he responded, I can't remember. I've been asking for one. Record review revealed that r#703 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The Annual Minimum Data Set Assessment ((MDS) dated [DATE] indicated the residents cognition was intact and required staff assistance for bathing and hygeine. Review of the shower task sheets for the past 30 days revealed the R#730 had last received a shower on 6/11/20 (12 days prior to the survey). At 12:30 p.m., during an interview with the facility's Director of Nursing (DON) she was made aware of the poor hygeine observed for R#703 and stated, We will take care of that right now. The DON said that she will be re-educating the staff on bathing residents and documenting shower/bathing on the task sheet in the electronic medical record. Review of the facility's undated policy titled, Giving a bed bathdocumented, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident ' s skin .The following information should be recorded on the resident ' s ADL record and/or in the resident ' s medical record: 1. The date and time the bedbath was performed. 2. The name and title of the individual(s) who performed the bedbath. 3. All assessment data obtained during the bedbath. 4. How tire resident tolerated the bedbath. 5. If the resident refused the bedbath, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. Notify the supervisor if the resident refuses the bedbath. Report other information in accordance with facility policy and professional standards of practice.
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 intakes number: MI 166 and MI 172. Based on interview and record review, the facility failed to appropriately monitor a one on one (Provides constant observation of and interaction by a designated staff) for one sampled Resident (R#702) of three residents reviewed for supervision, resulting in the resident being left unattended with a vulnerable demented resident (#701). Findings include: On 6/23/20 at 8:45 a.m., a review of the facility's investigation reported documented, Incident discovery date 3/17/20 at 12:45 a.m. documented, Incident summary: Administrator and Director of Nursing (DON) were called on 3/17/20 at approximately 1:05 a.m. by the supervisor Nurse D to report that R#702 was observed in the dining room lounge at approximately 12:45 a.m. sitting on the couch with his pants pulled down playing with his penis with both hands. Resident #701 was sitting on the couch next to him with her pants pulled down, saying No, No, No. Staff reported upon entering dining room they did not see residents having any physical contact or touching with one another. Residents were immediately taken to their rooms for assessment . The facility's investigation report also revealed Nurse C written statement documented, 3/17/20 writer heard resident say no loudly in the dining room. Writer left nurses' station to see what was going on and witnessed R#701 with her pants to her knees with no brief on and R#702 sitting next to her with his penis out. Writer separated the two and asked resident if she was okay. Resident was upset about the separation. Writer then went to see where the assigned one on one staff was and she was inside the resident's room. Another written statement by Nurse C 3/18/20 documented, After separating the residents in the dining room and going into R#702's room, I found the Certified Nursing Assistance (CNA) sleeping with a blanket on. A review of CNA B Interview/Statement Record conducted by the Administrator documented, CNA C reported that she was assigned to R#702 as a one on one for her shift. She reported she was sitting with R#702 in his room [ROOM NUMBER]-A. R#702 went into the bathroom (Ambulates Independently) approximately 12:30 p.m. aid closed door, within a few minutes CNA C went to the bathroom door and asked resident if he was ok and what was taking so long. R#702 reported he was trying to have a BM (Bowel Movement). After a few minutes while waiting for the resident to come out of the bathroom, Nurse A came into the resident's room and told her the resident was in the dining room. CNA C and Nurse A believed R#702 opened the bathroom door that adjacent the room and went out the other room's door and into the dining room directly across the hall. On 6/23/20 at 9:01 a.m., a review of the clinical record revealed, R#702 was initially admitted into the facility 12/24/19 and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R#702 was cognitively intact, required limited assistance of one person with Activity Daily Livening (ADLs) and required supervision of one person for ambulation. Review of R#702's Behavioral care plan dated 1/16/20 documented, R#702 has a behavior problem related to verbal aggression, yelling and cursing at staff, in addition to a lack of boundaries and personal space with peers. R#702 has behaviors related to sexually inappropriateness .masturbation in non-private areas .resident remain on one on one due to his inappropriate behavior towards others. Review of R#702's ADLs care plan dated 1/16/20 documented, The Resident needs assist of one everyday with dressing and undressing . On 6/23/20 at 10:40 a.m., observed R#702 lying in bed, alert and confused during an interview attempt. R#702 was asked, has he ever touched a female inappropriately. R#702 stated, I don't know anything about that. R#702 was asked again, did he remembers touching an undressed woman inappropriately in the dining room? R#702 stated, I don't remember anything like that. On 6/23/20 at 1:10 p.m., interviewed the DON. The DON was asked, was R#702 a one on one prior to the incident. The DON stated, I believe he was, but I will check. The DON was asked, why was he a one on one with care. The DON stated, I believe he was on a one on one because of his behaviors, he has sexually inappropriate behaviors. On 6/23/20 at 1:30 p.m. a one on one care policy was requested. The Corporate Compliance E stated, We don't have a one on one care policy. On 6/24/20 at 11:35 a.m., attempt to contact CNA B for an interview was unsuccessful.

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

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.