

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 834860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 6/26/2023
--	---	--	--

NAME OF PROVIDER OR SUPPLIER OMNI CONTINUING CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CONNER DETROIT, MI 48213
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	<p>INITIAL COMMENTS</p> <p>Omni Continuing Care was surveyed for a Recertification survey on 6/26/23.</p> <p>Intakes: MI00133225, MI00133355, MI00133553, MI00134860, MI00136281, MI00136609, MI00136929, and MI00137652.</p> <p>Census: 93</p>	F0000		
F0690 SS= D	<p>Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and</p>	F0690		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 834860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/26/2023
NAME OF PROVIDER OR SUPPLIER OMNI CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CONNER DETROIT, MI 48213		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure proper anchoring/securing of an indwelling urinary catheter for one (R73) of four residents reviewed for urinary catheters, resulting in pain and the potential for infection and skin trauma.</p> <p>Findings include:</p> <p>In an observation on 6/21/23 at 10:35 a.m., Resident #73 (R73) laid in bed and had a urinary cathete. Tea colored urine was observed in the tubing.</p> <p>Review of an admission record revealed, R73 admitted to the facility 11/4/22 and readmitted on 6/6/23 with pertinent diagnosis which included Obstructive and Reflux Uropathy (the backup of urine into the kidneys) and Benign Prostatic Hyperplasia (prostate pushes against the urethra and the bladder).</p> <p>Review of a "Minimum Data Set" (MDS) assessment, with a reference date of 5/10/23 revealed R73 had no cognitive impairment with a "Brief interview for Mental Status" (BIMS) score of 14 out of 15 and required an indwelling catheter.</p> <p>In an observation on 6/26/23 at 8:58 a.m., Certified Nursing Assistant (CNA) "B" prepared to perform ADL care for R73. CNA "B" performed hand hygiene and applied gloves. R73's catheter tubing hung to the right side and did not have a device to secure the indwelling catheter. R73's head of the penis was red and a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 834860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/26/2023
NAME OF PROVIDER OR SUPPLIER OMNI CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CONNER DETROIT, MI 48213		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>yellowish substance near the base of penis was present. R73 complained of pain when CNA "B" touched the catheter.</p> <p>In an interview on 6/26/23 at 9:30 a.m., CNA "B" reported R73 should have an anchor or leg strap on the catheter.</p> <p>In an interview on 6/26/23 at approximately 9:33 a.m., Licensed Practical Nurse (LPN) "C" reported R73 should have a leg strap and had a history of urinary tract infections.</p> <p>Review of a care plan revealed R73 had focus, "(R73) is at risk for urinary tract infection and catheter-related: has a Foley Catheter r/t (related to) obstructive uropathy" with a revised date of 5/2/23. Interventions include provide catheter care per policy.</p> <p>Review Physician orders revealed R73 had an order, "Secure Foley Catheter with Anchor/Leg strap" with a start date of 6/7/23.</p> <p>Review of a progress note with a date on 6/19/23 at 12:20 p.m. revealed R73 had a blood in urine and pain.</p> <p>In an interview on 6/26/23 at 11:06 a.m., the Director of Nursing (DON) reported applying an anchor for the catheter depends on the resident's needs. The DON then reported an anchor is required most of the time for a resident with a catheter.</p> <p>Review of an "Catheter Associated Urinary Tract Infection (CAUTI) Prevention" policy with a revised date of 8/17/21 revealed " To ensure appropriate technique in the care and maintenance of indwelling catheters ... 5. Secure catheter properly to prevent movement. A leg strap or tape may be used ..."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 834860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 6/26/2023
--	---	--	--

NAME OF PROVIDER OR SUPPLIER OMNI CONTINUING CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CONNER DETROIT, MI 48213
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F0842 SS= D	<p>Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date</p>	F0842		
----------------	--	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 834860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/26/2023
NAME OF PROVIDER OR SUPPLIER OMNI CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CONNER DETROIT, MI 48213		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure complete and accurate documentation was maintained in an Electronic Health Record (EHR) for one resident (R139) of 20 residents reviewed resulting in inaccurate and incomplete medical records with the the potential for inadequate care delivery.</p> <p>Findings include:</p> <p>A review of R139's EHR revealed 16 consecutive progress notes from 11/7/22 through 4/17/23 written by Nurse Practitioner (NP) "A" with the exact same documentation that included;</p> <p>"Hematuria (blood in the urine), continue to flush foley. UA (urinalysis) and cultures (C&S) reviewed, negative", (11/7/22, 11/9/22,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 834860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/26/2023
NAME OF PROVIDER OR SUPPLIER OMNI CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CONNER DETROIT, MI 48213	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>11/14/22, 11/16/22, 11/25/22, 11/28/22, 12/8/22, 12/15/22, 12/19/22, 12/22/22, 1/5/23, 1/23/23, 2/20/23, 3/20/23, 4/5/23, and 4/17/23). Review of R139's progress notes written by the physician and other nursing staff did not reveal any documentation to indicate the resident had hematuria during this time.</p> <p>A Urinalysis result for R139 collected 10/26/22 and reported on 10/27/22 indicated it was a 'Partial Report, Final to Follow". There was no additional Final Report of R139's urinalysis in his EHR as of 6/22/23.</p> <p>According to the EHR, R139 admitted to the facility on 10/19/19 with multiple diagnoses that included quadriplegia and required a supra pubic catheter (s/p catheter is a hollow flexible tube surgically inserted through the abdomen into the bladder) to drain urine.</p> <p>- On 10/26/22, NP "A" documented, "hematuria and a UA and C&S was ordered."</p> <p>- On 10/28/22 NP "A" documented hematuria follow-up. UA and C&S pending results. Continue to flush foley".</p> <p>- On 11/2/22, NP "A" documented R139's hematuria was resolved.</p> <p>During an interview on 6/22/23 at 9:34 AM the Director of Nursing (DON) reviewed R139's EHR. The DON said, " I reviewed all her (NP "A") notes. They all say the exact</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 834860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/26/2023
NAME OF PROVIDER OR SUPPLIER OMNI CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CONNER DETROIT, MI 48213	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>same thing. Its looks like she just copied and pasted her progress notes from 10/28/22 through 4/17/23." The DON continued to review R139's EHR and said, "There is no note from nursing that indicates resident had hematuria since October 27th. The resident's UA was from October and it's inconclusive. I don't know why we do not have the final report on this. I will call the lab. It (the final UA report) should be in there."</p> <p>On 6/22/23 at 12:15 PM during a phone interview with NP "A" she said, "I reviewed his (R139)'s medical record. I had been accidentally pasting an old note in his record. It's a mistake on my end. I wrote a note today indicating it was an error. The resident did not have any hematuria or UA since 10/26/22. I don't know why the final report of his UA isn't in his EHR. It should be."</p> <p>A review of R139's EHR revealed a progress note written by NP "A" on 6/22/23 as follows; "inaccurate documentation in regards to hematuria. Also UA and culture was never ordered, also wrong documentation. Please call our team with questions or concerns."</p> <p>On 6/22/23 at 12:30 PM the DON provided R139's final Urinalysis report dated 10/27/22. The report indicated "Negative" for infection. The DON said, "I'll have this uploaded into the resident's medical record. It should have been there earlier."</p> <p>According to the facility's policy for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 834860	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/26/2023
NAME OF PROVIDER OR SUPPLIER OMNI CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CONNER DETROIT, MI 48213	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"Documentation Expectations" last revised 11/1/2017;</p> <p>Healthcare personnel will complete documentation requirements as outlined by the company and recorded in the medical record using accepted principles of documentation.</p> <p>Be Specific. Entries should reflect factual statements.</p> <p>Be Complete. All facts and pertinent information related to an event, course of treatment, resident condition, response to care, and deviation from standard treatment (including the reason for the deviation) must be documented. If an original entry is incomplete, follow guidelines for making a late entry, addendum, or clarification.</p> <p>Procedure</p> <p>General</p> <p>1. Chart events as they occur and maintain chronological order.</p> <p>6. Preprinted forms: Only approved forms are to be used. Do NOT copy forms. All areas of the form are to be completed fully according to each form's instructions. If a field is not applicable, "MN/A" should be entered to show that the question was reviewed and answered.</p>			