STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235260	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Waterford	1901 N Telegraph Rd Waterford, MI 48328

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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34275

Based on interview and record review the facility failed to report to the Administrator and the State Agency an injury of unknown origin for one (R903) of one resident reviewed for abuse. Findings include:

A review of R903's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included, in part: end stage renal failure and heart disease. R903 census notes indicated the resident was discharged to the hospital on 7/29/24 and returned on 8/20/24. A review of the residents Minimum Data Set (MDS) revealed the resident was severely cognitively impaired and required extensive assistance with most Activities of Daily Living (ADLs).

Continued review of R903's clinical record revealed, in part, the following:

9/9/24- Nurse Notes: Resident has an <sic> red raised lump on the left side of the back head. Resident is unable to explain the cause, no c/o (complaints) of pain .Resident has been sent out to (name redacted) Hospital for observations . Authored by Nurse D.

9/9/24 - SBAR (Situation, Background, Assessment and Recommendation) Summary: .Send to Hospital for cat scan .

A request was made for any Incident and Accident (IA) regarding R903's injury of unknown origin. *It should be noted that the facility was not able to provide any IAs by the end of the survey.

9/9/24- Hospital Records: .Chief Complaint .Patient presents with Fall .EMS (Emergency Medical Services) states patient had a Suspected unwitnessed fall at (name redacted) facility .Patient is immobile and has to be moved with a Hoyer lift patients family does not believe patient fell .Patients family said they noticed a lump on his head after dialysis. There is actually 2 red lumps. Facility said there was no fall he was never found on the ground .Final diagnosis: closed head injury.

On 10/7/24 at approximately 2:35 PM, an interview was conducted with Nurse D regarding the red raised lump to the left side of R903's head. Nurse D reported that the resident returned from Dialysis at the facility and noted the bump/lump on the resident's head. The resident was not able to explain what happened. Nurse D noted that they informed the Unit Manager on duty (herein after Nurse E) and then the resident was sent to the Hospital. Nurse D was asked if they reported the injury of unknown origin to the Abuse Coordinator/Administrator and they noted they did not.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER Regency at Waterford		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N Telegraph Rd Waterford, MI 48328	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at approximately 2:47 PM, an interview was conducted with the Director of Nursing (DON). The DON was queried as to the facility's policy/protocol regarding injuries of unknown origin. The DON noted that staff should assess the resident and inform the provider and family as to what is going on. With respect to R903, the DON noted that hospital records could not determine the origin but records noted the resident was not in distress from the bumps and was sent back to the facility on the same day. When asked if the injury of unknown origin should have been reported to the Abuse Coordinator/Administrator they noted it should have. On 10/7/24 at approximately 3:05 PM, an interview was conducted with the Abuse Coordinator/Abuse Coordinator. When asked if they reported the resident's injury of unknown origin to the State Agency, they reported that they did not. A review of the facility policy titled, Abuse Prohibition Policy (last revised 9/9/22) documented, in part: Policy: Each guest/resident shall be free from abuse .Staff members .shall immediately report incidents of abuse and suspected abuse .Definitions: .Injuries of unknown source: An injury should be classified as an 'Injury of unknown source' when ALL of the following criteria are met: The source of injury was not observed by any person; and the source of the injury could not be explained by the guest/resident; and the injury is suspicious because of the extent of the injury or the location of the injury .Allegations by anyone who become aware of . abuse .must immediately report it to his/her Administrator .An incident Report .will be completed .The staff will report .injuries of unknown source to the Administrator and DON immediately .The Administrator .will notify the guests representative. Also, any State or Federal agencies .per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours .

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34208 This citation pertains to intake #146351. Based on interview and record review, the facility failed to ensure clinical documentation met professional standards for one resident (R901) of two residents reviewed for professional standards. Findings include: A complaint received by the State Agency alleged staff entered late progress notes and documented in the clinical record after a resident's death. A review of R901's clinical record was conducted and revealed a Late Entry progress note for 8/2/24 at 5:19 AM entered into the record on 8/9/24 at 9:38 PM, (seven days later) by Nurse 'B' that read, .Resident observed in bed unresponsive, no pluse <sic> or respirations noted .Hospice Nurse, physician and family notified . Continued review of R901's clinical record revealed Nurse 'B' documented the Effective outcome of as needed pain and anti-anxiety medications at approximately 6 AM, after the documented time of R901's death. On 10/7/24 at 3:17 PM, an interview was conducted with the facility's Director of Nursing regarding when the note regarding R901's death should have been entered into the record and they reported it should have been done right away, not several days later. A review of a facility provided policy titled, Medical Records Management revised 1/2022 was conducted and read, The facility must maintain medical records on each guest/resident, in accordance with accepted professional standards and practice and state and federal law. Medical records must be complete, accurately documented, readily accessible, systematically organized, and maintained in a safe and secure environment .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to intake #MI00147067 and MI00147277 Based on interview and record review the facility failed to complete accurate skin assessments, ensure residents were seen in a timely matter by wound staff/practitioners, ensure appropriate treatment and services/interventions were timely implemented for pressure ulcers for two residents (R#'s 902 and 903) of two residents reviewed for pressure ulcers. Resulting in R903 developing a stage 3 pressure ulcer to their sacrum, left heel and worsening of their right heel. Findings include: R903 A complaint was filed with the State Agency (SA) that alleged that R903 obtained wounds on both their heels and coccyx/sacrum while residing at the facility. They further noted that R903 was not turned frequently, and the facility failed to put physician ordered boots on the resident until two days prior to their discharge. Review of R903's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included, in part: end stage renal failure, heart disease and unspecified. R903's census notes indicated the resident was discharged to the hospital on 7/29/24 and returned on 8/20/24. A review of the resident's most recent Minimum Data Set (MDS) revealed the resident was severely cognitively impaired and required extensive assistance with most Activities of Daily Living (ADLs). Continued review of R903's clinical record revealed the following: 6/3/24- Braden Scale Assessment (tool to predict the likelihood of pressure ulcer development) - Score 15 (Low Risk). 7/29/24- Skin & Wound- Assessment: .New Wounds 'No'. 7/29/24- Nurses Notes: .resident in hospital . 8/20/24: Resident is a re-admit .resident has a hx (history) of right sided stroke .Resident has a wound noted on rt (right) heel, redness to groin/buttock . 8/20/24- Nursing Comprehensive Evaluation: .Section K. Skin .Does the resident have any skin conditions . Yes .Description: Site: Groin (Redness to groin) Coccyx (Blanchable redness to buttock) .Right Heel (wound) . *It should be noted that there were no further notes as to the description (ie. size, stage of the wound sites noted until 9/10/24 see notes below). 8/20/24-Order: wound care practitioner to eval (evaluate) and treat as indicated . * It should be noted that there was no indication that R903 was seen by the wound care practitioner until 9/17/24. 8/21/24-Order: Cleanse buttock with NS (normal saline) and pat dry. Apply triad and cover with foam patch for protection . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/21/24- Cleanse right heel with NS and pat dry. Apply skin prep and cover with Foam Patch for protection. 9/10/24-Total Body Skin Assessment - Late Entry: .Number of new skin conditions: 2 . 9/10/24- Nurses Notes: Late Entry:Writer called to resident's room by CENA (certified nursing assistant) with concerns of resident's wounds. Upon assessment it was noted that resident wound to buttock/sacrum has worsened, and a new injury was noted to left heel .new orders in place . Authored by Wound Nurse A. *It should be noted that this was the first note authored by Nurse A that was found in the resident's clinical record following re-admission to the facility on [DATE]. 9/10/24- SBAR (situation, background, assessment and recommendation): .Change in Condition/s . Evaluation are/were: Change in skin color or condition .Nursing observations, evaluation and recommendations are: New pressure injury noted to sacrum and left heel .Recommendations: Add to wound care case load . 9/10/24- Order: Clean left heel with wound cleanser, pat dry, apply betadine soaked gauze, ABD (large 5x9 abdominal dressing) and wrap with Keflex every day shift and as needed . 9/10/24- Order: Clean right heel with wound cleanser, pat dry, apply betadine soaked gauze, ABD and wrap with Keflex every day shift and as needed . 9/10/24 -Order: Clean sacrum wound with wound cleanser, pat dry, apply Medi honey gel and cover with a border gauze . 9/12/24 (Late Entry)- Resident at Risk-Created by Wound Nurse A (created date 9/16/24): .Resident at risk for wounds d/t (due to) decreased activity. Wound care to follow . 9/17/24 (lock date 9/19/24)- Skin and Wound Evaluation: .Type: Pressure .Stage: Stage 3 .Location: sacrum . acquired: Present on Admission .Area: 33.0 cm (centimeters) .Length: 8.8 cm .Width: 5.4 cm .Notes: Stage 3 pressure injury to sacrum, moderate amount of serous, no odor noted, wound be consists of 10% epithelial tissue and 90% slough .Education: Resident and family educated on repositioning as tolerated and elevating feet while in bed . *It should be noted R903 was discharged from the facility on/or about 9/18/24. 9/17/24-Wound Care- .Patient is being seen today for wound evaluation and assessment .Pressure ulcer of right heel, stage 3 .apply soft boots, elevate heels .pressure induced deep tissue damage of left heel .apply soft boots. Elevate heels . Pressure ulcer of sacral region, stage 3 .frequent repositioning. Apply pressure-relieving mattress . Care Plan: Focus: R903 has Actual impairment to skin integrity r/t (due too) Stage 3 coccyx wound, Stage 3 right heel wound DTI (deep tissue injury) .Interventions: .Apply Flow T 105 to protect skin while in bed . date initiated 9/10/24 .Apply (specify: Pressure relieving/reducing mattress, pillows, etc.) to protect the skin while in bed -date initiated 9/10/24 .Chair air cushion to w/c (wheelchair) or chair - date initiated 9/11/24 .Conduct weekly head to toe skin assessments and report new/abnormal findings to physicians as needed - date initiated 9/10/24 .Heel protectors while in bed .Date initiated 9/10/24 .Provide incontinent care and use moisture barrier treatment as needed after incontinent episodes - date initiated 9/10/24 .Turn and reposition as tolerated- date initiated 9/10/24 .Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface - date initiated 9/10/24 . (continued on next page)

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Regency at Waterford	1901 N Telegraph Rd Waterford, MI 48328

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at approximately 1:37 PM an interview and record review were conducted with Wound Care Nurse A. Nurse A reported they had been employed at the facility for approximately four months. Nurse A was queried regarding what appeared to be a delay in R903's assessments, treatment and interventions pertaining to wounds. Nurse A was asked why R903, who initially entered the facility (6/3/24) and was at the hospital from 7/29/24, with a re-entry date of 8/20/24 and noted to enter with a wound to the right heel and redness to the coccyx/sacral area was not assessed by them until 9/10/24 (twenty days later).Nurse A reported that they had been out on vacation. When asked about the order dated 8/20/24 that indicated the resident should be seen by the Wound NP (nurse practitioner). Nurse A reported that they were not sure as to the delay on the order and noted that there had been a change in Wound NPs. When asked why interventions were not put in place until 9/10/24, again Nurse A reported again that they were not in the facility for a period of time upon the resident's readmission. Nurse A did discuss that there was documentation (dated 9/10/24) that noted the residents pressure ulcers were unavoidable. However, when asked if all attempts to treat the wounds, including but not limited to interventions, were not implemented until 9/10/24 how could that the physician determine that, Nurse A did provide a response. On 10/7/24 at approximately 3:00 PM, an interview and record review were conducted with the Director of Nursing (DON). The DON was queried as to the delay in assessing and implementing interventions to R903. The DON reported that they were aware of delay in implementing interventions and recalled that the resident's family being upset as heel protector boots were observed in the resident's room, but they were not placed on the resident. The DON was asked to provide documentation that noted the resident was being turned and repositioned, however was not able to print the documents prior to exit. 34208 R902 On 10/7/24 at 11:05 AM, a review of R902's closed clinical record revealed they admitted to the facility on [DATE], discharged [DATE], and readmitted on [DATE]. On 7/23/24 R902 was seen for a wound care consult and revealed they developed a facility acquired stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising) pressure ulcer on their sacrum. The record revealed wound care treatments were initiated for the wound to the sacrum after the consult on 7/23/24 A review of R902's closed clinical record after their re-admission on 8/16/24 was conducted and a nursing admission assessment dated [DATE] revealed they readmitted to the facility with an open area to their sacrum. R902's physician orders, and August 2024 medication administration records (MAR) and treatment administration records (TAR) were reviewed and revealed no treatments were implemented to the sacral pressure wound (present prior to their transfer to the emergency roiagnom on [DATE]) until 8/28/24, 12 days after their re-admission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 1:36 PM, an interview with Nurse 'A', the facility's wound care nurse was conducted. They were asked about the process of identifying and treating pressure ulcers. They said the admission nurse performs a skin assessment, documents areas of concern in the clinical record, initiates treatments and care plans, and let's them (Nurse 'A') know of the wound(s) so the Wound Care Nurse Practitioner can see the resident. At that time, they were asked about R902 not having wound care initiated upon their re-admission and said they would look into it. Nurse 'A' followed up on 10/7/24 at 2:45 PM and said they did not find any evidence treatments were initiated for R902 upon re-admission. A review of a facility provided policy titled, Skin Management revised 8/2024 that read, It is the policy that the facility should identify and implement interventions to prevent the development of clinically unavoidable pressure injuries. Residents with wounds and /or pressure injury and those at risk for skin compromise are identified, and evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes .

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00146351 Based on interview and record review, the facility failed to ensure timely submission of physician/physician extender progress notes for each visit for two residents (R#'s 901 and 902) of two residents reviewed for progress notes. Findings include: R901 A review of R901's closed clinical record was reviewed and revealed the following: A progress note from Nurse Practitioner (NP) 'C' with an effective date of [DATE] at 12:00 AM, entered into the record on [DATE] at 9:34 PM. It was revealed this note was entered into the record after the resident's death on [DATE]. R902 A review of R902's closed clinical record was reviewed and revealed the following: A progress note with an effective date of [DATE] at 12:00 AM, created and entered into the record on [DATE] at 10:37 AM. A progress note with an effective date of [DATE] at 12:00 AM, created and entered into the record by NP 'C' on [DATE] at 10:39 AM. A progress note with an effective date of [DATE] at 12:00 AM, created and entered into the record by NP 'C' on [DATE] at 10:42 AM. A progress note with an effective date of [DATE] at 12:00 AM, created and entered into the record by NP 'C' on [DATE] at 10:44 AM. A progress note with an effective date of [DATE] at 12:00 AM, created and entered into the record by NP 'C' on [DATE] at 1:33 PM. On [DATE] at 3:17 PM, an interview with the facility's Director of Nursing was conducted regarding the expectation of physician/physician extender's responsibility for entering their progress notes in the record and said they should be entered in a timely manner. A review of a facility provided policy titled, Physician Services revised ,d+[DATE] was conducted; but, did not address timely entry of progress notes into the record.