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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>235333   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>11/01/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Regency, A Villa Center  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12575 S Telegraph Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194</b></p> <p>Based on observation, interview and record review the facility failed to maintain dignity while assisting during mealtime for one resident (R163) of three residents reviewed for dignity, resulting in the potential for feelings of embarrassment and low self-esteem.</p> <p>Findings include:</p> <p>On 10/29/2024 during a lunch meal observation on the fifth-floor dining room, certified nurse aide K (CNA) was observed feeding R163. During the observation R163 was observed positioned in a Broda Chair (a chair like a geriatric chair but with more versatile features for comfort staff flexibility). Occasionally, R163 was observed with a forward jerking movement. CNA K was observed standing on the resident's left side and shifting to the right trying to prompt R163 to eat the food displayed in front of the resident, as CNA K stood over R163 portions of the resident's pureed food dropped onto the resident's clothing.</p> <p>On 10/30/24 at approximately 12:40 P.M. R163 was observed being fed by CNA K, while attempting to sit in a dining room chair which was too low for the height of the Broda chair R163 was seated in. CNA K moved to the resident's left and right side prompting R163 to eat, commenting to others this chair is different than the old [NAME] chair.</p> <p>On 10/30/24 at 3:00 P.M. CNA K was interviewed concerning how had staff been in serviced to assist with feeding when a resident was seated in a Broda Chair? CNA K indicated R163 had previously had a geriatric ([NAME] Chair) and staff could sit comfortably and be at eye level with the resident during feeding. CNA K stated, we (referring to two other CNA's present) were trying to figure out how to feed the resident, the chairs we have will not allow us to be at eye level.</p> <p>In a subsequent interview and observation with Unit Manager H concerning staff education on feeding R163 while seated in the Broda Chair, UMH indicated staff should feed residents in the safest manner and should not be standing. The UM was unaware of any specific training staff had been provided in reference to the Broda Chair. During the observation UM H indicated it was a concern and further investigation was required to assist the staff in appropriately feeding the resident while in the Broda Chair.</p> <p>On 11/1/24 at approximately 12:05 P.M. the Director of Nursing was interviewed and acknowledged staff should be seated at eye level with the resident during feeding.</p> <p>(continued on next page)</p> |   |  |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>According to the Admission Record R163 was admitted to the facility 12/29/2022, with diagnoses which included: dementia with behavioral disturbance, schizoaffective disorder, repeated falls, functional quadriplegia, and adjustment disorder with anxiety. The Quarterly Minimum Data Set (MDS) dated [DATE] indicated R163 was severely impaired in cognitive skills for decision making and required extensive assistance of one person for eating.</p> <p>Review of the facility's policy titled Assistance with Meals, dated 3/2014 revised 10/2020, stated in part under section Titled Residents requiring Full Assistance: . 2) Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: Not standing over residents while assisting them with meals.</p> |   |  |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423</b></p> <p>Based on observation, interview and record review, the facility failed to maintain and respect the personal privacy by opening packages of one resident (R142) of two residents reviewed for privacy, resulting in a breach of personal privacy and the feeling of anger and disrespect.</p> <p>Findings include:</p> <p>On 10/31/2024 at 10:30 am, R142 discussed during Resident Council that their packages were being opened by staff.</p> <p>On 10/31/24 at 11:55 PM, R142 was observed in bed watching television. R142 was asked about concerns related to personal privacy and mail being opened. R142 said, Sometimes when a package is delivered to me, it's already opened .that's not right to open my mail .what if they take something .that makes me mad.</p> <p>10/31/24 11:38 AM, Receptionist P was interviewed and queried about when the residents receive mail/packages. Receptionist P stated, All packages are inventoried prior to delivery to the residents.</p> <p>On 10/31/24 at 12:16 PM, Facility Concierge Q was interviewed and queried about the process of delivering packages to residents. Facility Concierge Q said, Their (residents) boxes are inventoried then given to the residents.</p> <p>On 10/31/24 at 12:23 PM, the Administrator was queried about their process of receiving packages for residents. The Administrator said, We check their packages because we have to make sure there is not contraband . we will open before the resident or open in front of the resident.</p> <p>A review of R142 electronic medical record noted and admission on 11/22/2023 with a diagnosis of Hypertension, Low back pain, Falls, Prostate Hyperplasia, Chronic Embolism of Left Lower Extremity, and abnormal walking. A review of R142's Minimum Data Set (MDS) dated [DATE] noted A Brief Interview for Mental Status (BIMS) score of 14 out of 15 (intact cognition). The MDS also indicated that R142 was independent with bed mobility, sit to stand, upper body dressing, and eating. A review of R142's care plan noted the following: The resident has limited physical mobility r/t (related to) weakness. Date Initiated:12/08/2023 .Uses [NAME] .Uses Wheelchair.</p> <p>A review of the facility's policy Resident Rights dated 11/28/2017 noted the following:</p> <p>It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day .Privacy and Confidentiality-The right to send and receive mail and packages. Facility staff should never open your mail unless a resident allows it.</p> |   |  |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208</b></p> <p>Based on observation, interview, and record review the facility failed to change soiled linens for one resident (R131) of 27 reviewed for homelike environment resulting in R131 sleeping on soiled and damp linens and dissatisfaction with living conditions.</p> <p>Findings include:</p> <p>On 10/29/24 at 8:20 AM, R131 was observed lying on a soiled sheet that had a urine ring that was wet in the center and dried around edges and measured approximately two feet long and two feet wide. R131, reported that they (staff) should change the sheets after my shower.</p> <p>On 10/30/24 at 8:30 AM, R131's bed was observed to be soiled with a urine ring that was wet in the center and had dried edges. Soiled area measured approximately three feet long by two feet wide. R131 reported that staff had not changed the bed linens after shower yesterday and slept on the same linens last night. R131 further reported that sheets should be changed when they are dirty.</p> <p>Review of R131's electronic medical record (EMR) revealed admission into the facility on [DATE] with a diagnosis of traumatic brain injury. According to the Minimum Data Set (MDS) dated [DATE], R131 had intact cognition and requires assistance with ADLs.</p> <p>Review of ADL care plan revised on 6/19/23 documented, Toilet Use: The resident requires assistance x 1 for transfer to toilet, clothing management .</p> <p>Interview on 10/30/24 at 8:45 AM with Licensed Practical Nurse (LPN) A, After observing the soiled linens, it was reported that resident's linens should be changed when they are soiled.</p> <p>Interview on 10/30/24 at 2:48 PM with Director of Nursing (DON), it was reported that residents' linens should be changed on shower days and as needed. Residents should not have to lie on soiled sheets.</p> <p>Interview on 10/30/24 at 3:10 PM with Certified Nursing Assistant (CNA) A It was reported that residents should be checked often during each shift and soiled bed linens should be changed as needed.</p> |

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| <p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</b></p> <p>Based on interview and record review the facility failed to record, track, and respond to resident concerns/grievances for one (R15) of one resident reviewed for grievances resulting in R15's grievance not being addressed.</p> <p>Findings include:</p> <p>On 10/31/24 at 11:00 AM, R15 reported a missing item concern at the resident council meeting.</p> <p>On 10/31/24 at 11:30 AM, R15 was interviewed and said I gave Concierge (C) some clothing items in a bag that I no longer wanted. I left the room and when I came back there were some pants and shirts missing from my closet. I told Concierge (C) that the clothing was missing from my closet. This was within the last two weeks.</p> <p>Record review of the Electronic Health Record (EHR) revealed R15 was admitted to the facility on [DATE] with diagnosis that included chronic kidney disease, type two diabetes.</p> <p>Review of a Minimum Data Set (MDS) assessment for R15, with a reference date of 8/7/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition.</p> <p>On 10/31/24 at 11:55 AM Concierge C was interviewed and said R15 gave her a bag of clothes for donation. R15 did tell her there were missing clothes from her closet. Concierge C further said that she did not inform the abuse coordinator, nor did she fill out a grievance form.</p> <p>Record review revealed there were no grievance forms available for R15.</p> <p>On 10/31/24 at 2:42 PM the Nursing Home Administrator (NHA) was interviewed and said Concierge C should have filled out a grievance form and notified the abuse coordinator of the grievance so that the proper grievance process could be documented, investigated, and resolved.</p> <p>Review of the facility policy titled, Grievance Guideline dated 11/28/24, revealed in part: The facility will ensure prompt resolution to all grievances, keeping the resident informed throughout the investigation and resolution process. The facility grievance process will be overseen by the Administrator who will be responsible for receiving and tracking grievances through their conclusions, lead necessary investigations, communicate with residents throughout the process to resolution and coordinate with other staff.</p> |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39465</p> <p>Based on observation, interview, and record review the facility failed to properly position a resident for proper medication administration and failed to ensure that medication was administered according to physician orders for one (R5) out of twenty-seven residents reviewed for medication administration, resulting in the potential for less than therapeutic effects of the prescribed medication and placing the resident at risk for choking.</p> <p>Findings include:</p> <p>On 10/30/2024 at 8:30 a.m. during a morning medication administration, Licensed Practical Nurse (LPN) N was observed with five pills in a cup. R5 was observed lying flat in bed. LPN N did not assist the resident into a sitting position. LPN N proceeded to give R5 the medication cup with instructions to take the medication. R5 attempted to ingest the medication when the pills fell on and behind the bed leaving one pill in the cup. LPN N recovered three of the pills from the resident's bed and disposed of the three unidentified pills in a sharp container (a container to dispose unused medication). LPN N was observed pulling two of the same medication (Lisinopril oral tablet 20 MG (milligram) give one tablet by mouth one time a day for hypertension and Glipizide oral tablet 10 MG give two tablets by mouth in the morning for diabetes) that was previously pulled to administer to R5.</p> <p>During an interview, LPN N was asked what medication had to be pulled again. LPN N stated, the resident did not take any, so I am going to give the resident the two glipizide pills for her blood sugar and the Lisinopril pill for high blood pressure. LPN N made a second attempt to administer medication to the resident when R5 stated, I took one pill in the cup already, I think it was my blood pressure pill. LPN N said some of the pills must have fallen behind the bed and I didn't see them. LPN N did not administer the medication that was pulled again. LPN N acknowledged that there was no way that the medications not given could be identified. LPN N also said the resident should have been instructed to sit up in bed before given the medication that would have prevented the pills from spilling. LPN N did not verbalize contacting the physician for further orders for the medication that was not given.</p> <p>According to the electronic medical record, R5 was admitted into the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction (heart attack), type two diabetes mellitus, chronic obstructive pulmonary disease, history of pain due to trauma in unspecified joint, chronic diastolic (congestive heart failure), major depression disorder, hypertension, atherosclerotic heart disease, anxiety disorder and arthritis. R5's quarterly Minimum Data Set (MDS) assessment with a reference date of 7/18/2024 indicated R5 had intact cognition with a BIMS (brief interview for mental status) score of 15/15. A care plan initiated on 10/18/2024 for Activities of Daily Living (ADL) documented, R5 had actual ADL self-care performance deficit related to activity intolerance, confusion, fatigue, impaired balance, limited mobility of left lower and left upper extremities.</p> <p>Review of the Physician's order revealed as following:</p> <p>- Lisinopril oral tablet 20 MG (milligram) give one tablet by mouth one time a day for hypertension start date 9/10/2024.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>- Zolofit oral tablet 50 MG give one tablet by mouth one time a day for depression start date 9/13/2024.</p> <p>-Glipizide oral tablet 10 MG give two tablets by mouth in the morning for diabetes start date 6/28/2024.</p> <p>-Clopidogrel Bisulfate oral tablet 75 MG give one tablet by mouth one time a day for blood thinner start date 6/28/2024.</p> <p>-Docusate Sodium oral capsule give 100 MG by mouth in the morning for bowel management start date 6/27/2024.</p> <p>On 11 /1/2024 at 12:56 p.m., the Director of Nursing (DON) was interviewed and was asked to explain the proper procedure to administer medication to a resident who is lying flat in bed. The DON said the nurse should have sat the resident up in bed or let her head up to keep the resident from choking. The DON was informed of the spill medications. The DON said that would have prevented the spilled medications and the resident would have received the prescribed dose of medications. The DON also said the nurse should have called the physician after knowing the resident did not receive the prescribed doses.</p> <p>Review of the Facility's April 2018 Medication Administration General Guidelines Policy: Medications are administered as prescribed in accordance with good nursing principles and practices 18) The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested. This is noted on the medication administration record, and action is taken as appropriate.</p> |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15194</p> <p>Based on observation, interview, and record review the facility failed to provide ADL assistance for three (R107, R5, and R110) of 27 residents reviewed for ADL care resulting in unkempt hair, jagged nails, unshaven facial hair, and lack of showers/bedbaths.</p> <p>Findings include:</p> <p>R107</p> <p>On 10/29/24 at 12:31 P.M. R107 was observed in his room with portions of his hair pulled back into a rubber band. The resident's facial beard had grown 2-3 inches with particles of food stuck in between the facial hair. In the front of the resident's clothing drops of food were attached to the resident's clothes.</p> <p>During the observation CNA J was observed informing residents and staff I will try and shave this resident today, I am not on that set today. CNA J indicated each nurse aide was assigned their designated residents to shower and on that day residents were given a shave, nails cleaned if possible.</p> <p>On 10/30/24 at 8:51 A.M. R107 was observed in the dining room, the resident's hair was knotted and matted around the edges of the hair line. The remaining portion of the resident's hair was pulled back in a matted ponytail. The resident's nails were jagged and needed trimming.</p> <p>Review of the Care Plan Section of the Electronic Medical Record (EMR) titled: R107 has actual ADL self-care performance deficit r/t senile degeneration of the brain. Under the intervention section stated in part bathing/showering and personal hygiene: The resident required extensive assistance by one staff with bathing, showering, personal hygiene and oral care.</p> <p>On 10/30/24 at 3:00 P.M. review of the Task Assignment portal for R107 revealed the resident was scheduled for a shower/bathing on Tuesday and Friday 7am-3:00 P.M. and PRN. Review of the task assignment was blank and did not provide any evidence of a shower, nail care or shave being provided to the resident.</p> <p>On 10/31/24 at 3:00 P.M. Registered Nurse (RN) H was asked to verify the last time R107 received a shower. RN H indicated on shower days residents should receive nail care and be provided a shave. During this time RN H could not provide any evidence of R107 receiving a shower on Tuesday, 29. of October. RN H indicated R107 had been given a shower but staff probably had not documented the task in the portal.</p> <p>At 3:10 P.M., CNA I spoke out and stated, I usually have (R107) in my set, I was off on Monday 10/28/24, but the resident's hair is usually braided, and we (referring to the CNA's) do not have anyone to braid hair, so they just pulled it back, it is matted but maybe tomorrow I can wet it and comb his hair. R107 rarely refuses care he normally goes to the beauty salon, R107 looks better when shaved, CNA J does shave the men when possible.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 11/1/24 at 10:04 A.M. interview with RN E reported, We did not develop a Care Plan for the resident's hair or grooming. We thought R107 was scheduled to go to the beauty salon, but after reviewing the schedule, we realized he was not on the schedule.</p> <p>Review of the Admission Record R107 was readmitted to the facility on [DATE], with diagnoses of senile degeneration of the brain, dysphagia following cerebral infraction, sepsis, displaced intertrochanteric fracture of the left femur, speech and language deficit, paranoid schizophrenia and dementia without behavioral disturbance.</p> <p>According to the Minimum Data Set (MDS) dated [DATE], R107 had long and short term memory impairments, was severely impaired in cognitive skills for decision making and required supervision and one person physical assistance to perform Activities of Daily living.</p> <p>41423</p> <p>R5</p> <p>On 10/29/24 at 1:11 PM, R5 was observed in their room sitting in a wheelchair. R5 was observed with thick hair on their chin and upper lip. In addition, their hair was not combed or styled neatly. When queried regarding care received at the facility, R5 stated, I can't do much because I can't walk .I wish they would help me shave this hair off my face because I have a (mate).</p> <p>A review of R5's electronic medical record noted an admission to the facility on [DATE] with a diagnosis of Stroke affecting the left side, Chronic Obstructive Pulmonary Disease (breathing disorder), Diabetes, Muscle Weakness, Heart Failure, Optic Atrophy (damage of the eye nerve), and Contracture of Right Shoulder.</p> <p>A review of R5's Minimum Data Set (MDS) dated [DATE] noted A Brief Interview for Mental Status (BIMS) score of 15 out of 15 (intact cognition). The MDS also indicated that R5 required supervision or touching assistance with personal hygiene.</p> <p>A review or R5's care plane noted: Has actual ADL (activities of daily living) self-care performance deficit r/t (related to) Activity Intolerance, Confusion, Fatigue, Impaired Balance, Limited Mobility .Dated 10/31/2021.</p> <p>On 11/01/24 at 8:28 AM, CNA R was interviewed and asked if they perform shaving assistance to female residents during care. CNA R said, I will if they ask.</p> <p>On 11/01/24 at 9:29 AM, The Director of Nursing (DON) was interview and queried about residents ADL care including shaving. The DON said, They should be offered a shave.</p> <p>47964</p> <p>R110</p> <p>On 10/29/24 at 10:29 AM R110 was interviewed and said, I haven't had a shower or bed bath in two weeks and I would like to get cleaned up. I'm supposed to get showers on Tuesday and Fridays.</p> <p>(continued on next page)</p> |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Regency, A Villa Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12575 S Telegraph Rd<br>Taylor, MI 48180 |  |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 10/30/24 at 9:19 AM R110 stated, I did not get a shower last night.</p> <p>Record Review of the Electronic Health Record (EHR) revealed R110 was admitted to the facility on [DATE] with diagnoses that included morbid obesity and left above knee amputation.</p> <p>Review of a Minimum Data Set (MDS) assessment for R110, with a reference date of 8/30/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated intact cognition and R15 required substantial/max assist for showers.</p> <p>Record review of R15's shower log revealed shower given by Licensed Practical Nurse (LPN) D on 10/15/24 at 14:59, 10/22/24 at 14:59 and on 10/29/24 at 14:59 and not applicable on 10/18/24.</p> <p>On 10/30/24 at 2:43 PM the Assistant Director of Nursing (ADON )E was interviewed and said the shower log was not accurate and that the assigned Certified Nursing Assistant (CNA) should have documented on the shower log not the nurse. The ADON identified LPN D as the night supervisor. The ADON E agreed R110 has not had a shower since 10/11/24.</p> <p>On 11/01/24 at 9:36 AM the Director of Nursing (DON) was interviewed and said the CNA should have provided showers as scheduled and the shower log needed to be accurate.</p> <p>Review of the facility policy titled ADL, Functional Mobility and Resident Care undated revealed in part . Shower/bed baths: Follow shower schedule, which requires regular showering at least 2x weekly. Shaves: Assure facial hair is removed safely. Hair care: Wash and dry if needed, comb/brush and style. Nail care: Assure nails are cleaned and trimmed. Foot care: Assure nails are cleaned and trimmed. Toileting: Assist resident with toileting providing support as needed. Check resident throughout the shift for care and hygiene needs. Provide incontinence care, peri care and preventative skin care appropriately throughout the shift. The standard for ADL checks is at least every 2 hours.</p> |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</b></p> <p>Based on observation, interview, and record review the facility failed to follow standards of practice for respiratory care for one resident (R162) out of two residents reviewed for respiratory care, resulting in the improper storage of a nebulizer mask and the potential for cross-contamination.</p> <p>Findings include:</p> <p>On 10/29/24 at 10:59 AM R162's nebulizer mask was observed hanging on the dresser drawer next to the bed. R162 was asked if there was a storage bag for the nebulizer mask when not in use. R162 replied I don't know if there is a bag I hang it on the dresser when I'm done with the treatment. There was no storage bag observed.</p> <p>On 10/30/24 at 9:00 AM R162's nebulizer mask was observed hanging from the dresser drawer next to bed.</p> <p>On 10/30/24 at 1:30 PM R162's nebulizer mask was observed hanging from the dresser drawer next to bed.</p> <p>Record review of Electronic Health Record (EHR) revealed R162 was admitted into facility on 5/18/23 with a pertinent diagnosis of chronic obstructive respiratory disease (COPD). According to the Minimum Data Set (MDS) dated [DATE], R162 had intact cognition with a Brief Interview of Mental Status (BIMS) of 15/15.</p> <p>On 10/30/24 at 2:07 PM Licensed Practical Nurse (LPN) F was interviewed and said R162's nebulizer mask hangs from her dresser and acknowledged it should be stored in a bag and dated.</p> <p>On 11/1/2024 at 9:56 AM the Director of Nursing (DON) was interviewed and said nebulizer masks should be stored in a bag and dated.</p> <p>Review of the facility policy titled Administering Medications through a Small Volume Nebulizer revision date 11/2013 revealed in part Rinse and disinfect the nebulizer equipment according to facility protocol, allow to air dry on a paper towel. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it.</p> |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>15194</p> <p>Based on observation, interview and record review, the facility failed to provide a safe and functional environment for two residents (R54) and (R147), resulting in dissatisfaction with the resident's home an a increased risk for harm.</p> <p>Findings include:</p> <p>R54</p> <p>On 10/31/24 at 2:02 P.M. during an interview with R54, the resident complained that her bathroom did not get warm or hot water. The resident gestured and explained the faucets only ran cold water. The temperature in the hand sink registered 54 Degrees Fahrenheit.</p> <p>During an observation of the bathroom the hand sink faucets were checked. There was no hot or warm water. The cold-water faucet was loose, and the water continuously ran even when placed in the off position.</p> <p>Above the bathtub the ceiling walls were cracked, had broken plaster and peeling paint. Holes and pieces of plaster were suspended from the ceiling over the tub. Around the base of the bathtub a loose cove base was noted.</p> <p>On 11/1/24 at 10:30 A.M. in an observation of the resident's room Maintenance Director M indicated the entire unit was going to be remodeled and this included R54's bathroom. When queried how long it would be before the resident had warm water, Maintenance's Director M indicated no work order had been put into the system to address the water temperature and the broken, leaking faucet.</p> <p>On 11/1/24 at 12:05 P.M. during interview with the Administrator concerning the condition of the bathroom in R54's room, the Administrator indicated the facility was in the process of remodeling and plans included remodeling the unit that the resident resided on next. When asked if there was a target date for addressing the resident's bathroom the Administrator stated, I just know that unit is scheduled next.</p> <p>41423</p> <p>R147</p> <p>On 10/29/24 at 1:11 PM, R147 was observed in bed on their side. R147 pointed to the call light system on the wall that displayed exposed wires protruding out and a long white wire (about the length of a yard stick) hanging down. In addition, the white wire had an outlet cover dangling from the middle of the wire. R147 stated that sometime his call light was not answered and thinks it's related to the hanging wires.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 10/29/24 at 1:25PM, Unit Manager S was interviewed and queried about the call light system's loose wires hanging from the wall. Unit Manager S stated, The wires should not be exposed .I put a work order in last week .But the call light still works.</p> <p>On 10/30/24 on 1:47 PM, Maintenance Director M was interviewed and asked about the call light system's exposed wires hanging from the wall. Maintenance Director M said, The resident keeps pulling it out of the wall.</p> <p>On 11/01/24 at 9:35 AM, The administrator was interviewed and queried about the exposed wires hanging from the wall of the call light system. The Administrator said, There was a work order placed so it should have been taken care of.</p> <p>A review of the facility's policy Preventative Maintenance (TELS) and Inspection (not dated) noted the following: It is in the policy (facility's name) that in order to provide a safe environment for residents, employees, and visitors, a preventative maintenance program (TELS) has been implemented to promote the maintenance of equipment in a state of good repair and condition. Routine inspections promote safety throughout the facility and aid in keeping equipment in good working order and operating in accordance with manufacturer's guidelines. Regular inspection, testing, and replacement or repair of equipment and operational systems contribute to preservation of the facility's assets .A system for electronic work orders is established in TELS among staff, and Maintenance personnel that provides rapid communication regarding equipment problems.</p> |   |  |

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| <p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>47964</p> <p>Based on interview and record review the facility failed to ensure annual Dementia Management and Abuse training were performed for one Certified Nurse Assistant (CNA) G out of five CNAs reviewed for in-service training resulting in the potential for unmet resident care needs.</p> <p>Findings include:</p> <p>On 10/31/24 at 2:24 PM, review of five CNAs in-service training education content revealed the following:</p> <p>CNA G Date of hire (DOH)- 6/2/2009. Review of a facility provided transcript dated 6/2/23 through 6/2/24 for CNA G, failed to identify abuse and dementia management training.</p> <p>On 10/31/24 at 3:05PM the Assistant Director of Nursing (ADON) E was interviewed and said there was no record of abuse and dementia training for CNA G and said the training was due on 6/2/24. When queried about the significance of CNA trainings, ADON E stated, It is important to have trainings for the CNAs to meet their requirements and to provide education for what they do daily to meet resident needs.</p> <p>On 11/01/24 at 10:01 AM the Director of Nursing (DON) was interviewed and agreed that CNAs are expected to have yearly training that includes abuse and dementia management.</p> <p>Review of the facility policy titled Training Requirements Guideline revealed in part: . At a minimum training topics for all staff must include: Dementia management and resident abuse prevention and must be no less than 12 hours per year.</p> |   |  |