STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235422	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Chene	2295 E Vernor Highway Detroit, MI 48207

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI149002. Based on observation, interview, and record review the facility failed to ensure appropriate PEG (percutaneous endoscopic gastrostomy (thin flexible tube inserted through the skin of the abdomen into the stomach to deliver nutrition and hydration) tube care was provided including enteral/tube feedings (liquid nutrition delivered through a PEG tube) and water administration for one (R901) of three residents reviewed for PEG tube care, resulting in R901's not receiving the prescribed amount of enteral/tube feeding or water and peg tube care not being provided in accordance to the physician's orders. Findings include: (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/25 at approximately 10:20 AM, R901 was observed lying in bed with tube feeding infusing through a PEG tube using an infusion pump to regulate the rate and amount. The tube feeding bag was unlabeled, undated, and there was no time to indicate when the tube feeding was hung. There was approximately 500 milliliters (ml) remaining in the tube feeding bag. The water flush bag was unlabeled, undated, and without a time to indicate the time it had been hung. The bag was completely full with approximately 1000 ml remaining in the water flush bag. The infusion pump indicated that the tube feeding rate was programmed to run at 75 ml /hr (75 ml per hour). The water flush rate was not programmed and had a rate of 0 (zero) ml/hr. An irrigation set was hanging in a bag on the infusion pump's pole that was unlabeled and undated. A soiled split 4 x 4 gauze (pre-cut gauze dressing to allow the dressing to lay flat when covering an external catheter insertion site) was observed lying in the residents bed (not adhered to the resident) with dried dark reddish colored drainage on it. At this time Licensed Practical Nurse (LPN) B came to the resident's bedside and said, I'm going to shut her tube feeding off now. It's time to take it down. LPN B was asked about the resident's tube feeding and water flush orders and replied, It (tube feeding) goes up at 4:00 PM and runs for 18 hours, so it comes down at around 10:00 AM. LPN B was asked about the full water bag and said, Oh, yeah this is wrong. The water flush wasn't programmed at all. That's why this is full, she (R901) didn't get any water last night. LPN B went on to say that R901's tube feeding port broke sometime last night and the resident went out to the hospital to have a new PEG tube inserted. LPN B could not say how long the resident was out of the facility, when the tube feeding and water got restarted, or how much feeding or water the resident actually received from 1/5/25 at 4:00 PM until now. There is no way to tell when the feeding bag got started. There is no date or time on it. The infusion pump was inspected and indicated that only 705 ml of tube feeding had been infused since it started. There is no start date or time on the pump's display screen, only the amount infused since the last start time. LPN B was then asked about the 4 x 4 split gauze that was lying on the resident's bed and said, Yeah that is supposed to be around her PEG tube insertion site. They just re-inserted it last night at the hospital. I don't know why it's just sitting there. Doesn't look like it was taped on. I'll re-dress it. Upon inspection R901's PEG tube insertion site was open to air, no dressing on it with a small amount of reddish drainage around it. R901 did not have an abdominal binder in place. A review of R901's Electronic Health Record (EHR) revealed the resident admitted to the facility on [DATE] with multiple diagnoses that included Alzheimer disease and a PEG tube. According to the physician's orders dated: - 7/4/24: Abdominal binder in place for PEG tube securement. - 7/6/24: PEG tube cleanse PEG tube site with mild soap and water pat dry, apply 4 x 4 split gauze and secure with tape daily and as needed. - 12/23/24; enteral feeding Vital 1.5 via PEG tube at 75 ml/hr for 18 hours (up at 4:00 PM and down at 10:00 AM) WHEN total volume 1,350 ml is infused. Water flush via PEG tube 90 ml every other hour during enteral/tube feeding UNTIL 810 ml is infused. A review of the Medication Administration Record (MAR) revealed there was no documentation of the amount the tube feeding or water the resident actually received. The MAR only reflected the time the tube feeding and water flushes were started and then they were completed. There is no progress note to indicate when R901's PEG tube malfunctioned or when the tube feeding and water flushes were initiated on 1/5/25 or 1/6/25. A review of the R901's recorded weights were stable. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan for nutrition/hydration status initiated on 7/5/24 and revised on 12/4/24 included the following intervention; - Administer tube feeding and water flush per physician's orders. -Provide PEG tube care as ordered. On 1/6/25 at approximately 11:30 A.M. the Director of Nursing (DON) acknowledged that R901 did not receive the prescribed amount of enteral/tube feeding or water flush for 1/5/25 and 1/6/25. The DON said she would call the physician for bolus orders, Both the tube feeding bag and water bag should have been labeled, dated, and timed. I don't know why the nurse didn't do that. The pump says the resident got 705 ml of tube feeding and no water. The doctor will probably order boluses throughout the day to equal 1,350 ml of tube feeding and the 800 ml of water that was originally ordered. The DON could not explain why the 4 x 4 split gauze was not properly adhered to the resident's PEG tube insertion site or why the abdominal binder was not applied. According to the facility's Enteral Nutrition policy effective 9/22/23 in part read: Guidelines . 5. The nurse obtains an order for enteral feeding, the order should include the following information: The formula to be used. The rate and/or timing of administration. Total volume to be given per 24-hour period . * Volume of water given as water flush, and before and after medications 13. The irrigation syringe is changed every 24 hours and is labeled with the resident's name and date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI00149002. Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices related to enhanced barrier precautions (EBP) for one resident (R901) of three residents reviewed for wound and PEG tube care (percutaneous endoscopic gastrostomy (thin flexible tube inserted through the skin of the abdomen into the stomach), resulting in the potential for the spread of infection. Findings include: On 1/6/25 at 10:30 AM, R901 was observed lying in bed with tube feeding running though a PEG tube by using an infusion pump to regulate the rate of feeding. R901's brief and gown were not covered by a sheet or blanket and were visibly soiled with a brownish liquid. A soiled split 4 x 4 gauze (pre-cut gauze dressing to allow the dressing to lay flat when covering an external catheter insertion site) was observed lying in the residents bed (not adhered to the resident) with dried dark reddish colored drainage on it. At this time Licensed Practical Nurse (LPN) B and Certified Nursing Assistant (CNA) C entered the resident's room to assist with incontinence care. Both LPN B and CNA C applied gloves and repositioned the resident for incontinence care. CNA C began removing the resident's soiled brief. LPN B was asked if there were any gowns available in the facility and replied yes. CNA C removed R901's soiled dressing on her sacral area and continued to provide incontinence care while LPN B assisted with positioning of the resident. Both LPN B and CNA C were asked about Enhanced Barrier Precautions. At this time LPN B said, Yes, we follow enhanced barrier precautions. We should be wearing gowns because they (R901) have a wound and PEG tube. LPN B left the resident's room to obtain gowns for them (LPN B and CNA C). It was observed that R901 did not have any signage on her door to indicate there were EBP in place and no Personal Protective Equipment (PPE) supply cart was inside the resident's room or outside the doorway. Staff had to go down the hall and into the utility room to acquire PPE. On 1/6/25 at 11:30 AM the Director of Nursing (DON) was asked about the facility's EBP process. The DON said, 'Yes, I know they did not put a gown on when the did the resident's wound or PEG tube care. I don't know why they didn't put the right PPE on. We inservice them on it over and over again. Maybe it's because we moved the resident to another room and forgot to put the sign and PPE cart in there, but they still should know. The facility's EBP policy was requested at this time. According to the R901's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included Alzheimer disease and a PEG tube. A physician's order dated 9/11/24 reads Enhanced Barrier Precautions related to PEG tube and wound. A care plan for impaired skin integrity; pressure ulcer revised on 9/19/24 included the following intervention; Enhanced Barrier Precautions. According to the facility's policy for Enhanced Barrier Precautions (EBP) effective 4/1/24 in part read: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the intent of this facility to use Enhanced Barrier Precautions (EBP) in addition to Standard Precautions for preventing the transmission of CDC targeted multidrug-resistant organisms (MDROs). Enhanced Barrier Precautions are indicated for residents with any of the following: 1) infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO and should remain in place for the duration of a resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that place them at higher risk. Chronic Wounds generally include, but are not limited to, chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers. Shorter-lasting wounds such as skin breaks or skin tears that require an adhesive bandage are not included. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies. IMPLEMENTATION Post signage for precautions on the door or wall outside of the residents room indicating the type of precautions and required PPE (e.g., gown and gloves) Make PPE, including gowns and gloves, readily available to staff. Ensure staff access to ABHR (alcohol- based hand rub) Position a trash can inside of the resident room and/or near the exit door for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room GLOVES, GOWNS AND HAND HYGIENE A. Health care personnel caring for residents on Enhanced Precautions should wear gloves and gowns during high-contact resident care. Examples of high contact resident care activities requiring gown and glove use: Dressing Bathing/showering Transferring