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	04/19/2024

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

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview, and record review the facility failed to maintain dignity by not dressing one resident (R16) in personal clothing out of one resident reviewed for dignity, resulting in verbal frustration and impaired mental and psychosocial well-being. Findings include: On 4/16/2024 at 12:26 p.m., R16 was observed in the hallway sitting in a wheelchair fully dressed. R16 reported there was a problem wearing other resident's clothes. R16 stated, These clothes I am wearing are not [NAME] and I want to wear my clothes that I came into the facility with. The clothes R16's was wearing revealed no resident's name. Observed R16' s closet with a coat, three jackets, two sweaters, one blouse with pants and a blanket. R16 was asked how it feels to wear other resident's clothes. R16 head drop with a saddenned face and stated, I don't like it, I don't know who had those clothes on and I don't want to wear them. On 4/18/2024 at 10:02 a.m. R16 reported while dressed in a gown in bed, wanting to be dressed and out of bed every day. Observed R16 closet with a coat, pajamas pants, three jackets, two sweaters, one blouse with pants and a blanket. R16 reported personal clothes missing for about two weeks. R16 also reported social service was told and nothing was done. On 4/18/2024 at 10:06 a.m. R16 assigned Certified nursing assistance (CNA) O was interviewed regarding R16 personal clothes. CNA O said R16 will be dressed if there are clothes in the closet. CNA O stated, 'I looked in the closet the other day and she had only one pair of pants and a top. I had to go find her something to wear. I went to laundry, not for her personal clothes but miscellaneous clothes. CNA O said miscellaneous clothes belongs to another resident that had no name on them. CNA O confirmed that R16 clothes had been missing for a while. According to the electronic medical record, R16 was admitted into the facility on [DATE] with diagnoses of dementia, diabetes mellitus type two, malignant neoplasm of stomach, and major depressive disorder. R16 quarterly Minimum Data Assessment (MDS) with a reference date of 2/18/2024 indicated R16 was cognitive intact with a BIMS (brief interview for mental status) score of 14/15. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Activity Daily Living (ADLs) care plan date reviewed 2/18/2024 documented, R16 has an ADL self-care performance deficit and requires assistance with ADLS, and mobility related to weakness. Encourage resident to participate to the fullest extent possible with each interaction. Interventions for Dressing: R16 requires extensive assistance to dress. Review of R16's admission Resident Personal Belongings Inventory List dated 8/12/2023 revealed, eight pair of pants, eight shirts/blouses, one pajama, two gowns, three pairs of socks, three sweaters, two coats, one dress, two seat shirts, three pair of slippers, and one jackets. On 4/18/2024 at 3:02 p.m. Social Services F said during an interview that an inventory sheet is the residents' personal items brought with them upon admission that is completed by the CNAs or Nurses. On 4/18/2024 at 3:18 p.m. an interview with Laundry/Housekeeping Supervisor Q said the washing process for residents' clothes takes thirty to forty-five minutes depending on the load. One or two weeks is not normal for any resident to not have their clothes returned in their closet. On 4/19/2024 at 12:02 p.m. the DON said during an interview that it's the residents own personal choice to wear their own personal clothes. R16's clothes should have been in the closet during the survey because it takes one day to wash and return residents clothes to their closet. According to the facility's revision date 3/28/2024 Resident Dignity & Personal Privacy policy: The facility provides care for residents in a manner that respects and enhances resident's dignity, individuality, and right to personal privacy. -Dress in appropriate and desired clothing.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for one resident (R43) and a wheelchair provided for one resident (R108) of six residents reviewed for accommodation of needs, resulting in unmet care needs. Findings include: R43 On 4/16/2024 at 12:32 p.m., R43 was observed lying in bed with no call light within reach. During an interview, R43 was looking for the call light to get assistance to be repositioned and confirmed being uncomfortable. R43 stated, I can't find it (the call light). On 4/16/2024 at 1240 p.m., Licensed Practical Nurse (LPN) H was interviewed regarding the call light use and purpose. LPN H said, the purpose of a call light is to call for assistance. LPN H confirmed the call light was not within reach for R43. LPN H reported resident needed to be repositioned for comfort and safety. According to the electronic medical records, R43 was admitted into the facility on [DATE] with diagnoses of dysphagia (difficulties in swallowing), chronic obstructive pulmonary disease, hemiplegia (complete paralyzed on one side of the body) and hemiparesis (partial weakness) following cerebral infarction (stroke) affecting left non-dominant side, and contracture of muscle of left upper arm and hand. R43's quarterly Minimum Data Set (MDS) with a reference date of 2/14/2024 indicate R43 had severe cognition impairment with a BIMS (brief interview for mental status) score of 4/15. Review of the 2/14/2024 reviewed date ADLS care plan revealed, R43 has an Activity Daily Living (ADL) performance deficit and requires assistance with ADLs and mobility related to weakness . Interventions: -Encourage resident to use bell/call light to call for assistance. Review of the 2/14/2024 reviewed date Fall care plan revealed, R43 is at risk for fall related injury and falls related to weakness. Interventions: -Keep the resident's environment as safe as possible .call light within reach, commonly used items within reach. On 4/19/2024 at 12:02 p.m., the Director of Nursing (DON) reported during an interview that the call lights should be always within reach of the residents, and call lights are used for assistance like asking for a glass of water and in emergencies for example if a resident can't breathe. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's 2/15/2022 Call lights policy revealed, Call lights will be placed within the guest's reach and answered in a timely manner. 39958 R108 In an interview on 4/16/24 at 12:26 p.m., R108 reported not having a wheelchair to get up. There was no wheelchair observed in R108's room or bathroom. In an observation on 4/17/24 at 11:56 a.m., R108 laid in bed and there was not a wheelchair or walker in R108's room. Review of an Admission Record revealed, R108 admitted to the facility on [DATE] with pertinent diagnosis which included injury to left lower leg. Review of a Minimum Data Set (MDS) assessment dated of 1/31/24 revealed R108 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 15 out of 15. In an interview on 4/17/24 at 12:01 p.m., Therapy Manager M reported resident came to the facility from the hospital with a fractured hip. Therapy Manager M then reported it is the facility's responsibility to provide a resident with a walker and wheelchair. In an observation on 4/19/24 at 9:13 a.m., there was not a wheelchair in R108's room or bathroom. In an interview on 4/19/24 at 11:10 a.m., the Director of Nursing (DON) reported every resident should have a wheelchair. The DON then reported residents should have a wheelchair in case of an emergency.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on interview, and record review, the facility failed to ensure Preadmission Screening (PAS)/ Annual Resident (ARR) Mental Illness/ Intellectual Disability/ Related Conditions Identification forms DCH-3877 and/or DCH-3878) documents were reviewed, revised, and sent to the local state agency for review and/or evaluation for intellectual/ developmental disability needs for one (R21) of three residents reviewed for PASSARs, resulting in the potential for unmet intellectual/ developmental disability care needs. Findings include: Review of an admission Level I screen dated 1/29/24 revealed R21 had no mental illness or dementia. R21 did not have a Level I screen after 1/29/24. Review of an Admission Record revealed, R21 admitted to the facility on [DATE] with pertinent diagnosis which included bipolar disorder and paranoid personality. Review of a Minimum Data Set (MDS) assessment dated of 2/3/24 revealed R21 had cognitive impairment with a Brief interview for Mental Status (BIMS) score of 9 out of 15 and took antipsychotic medication. In an interview on 4/17/24 at 1:21 p.m., Social Services Tech N reported R21's PASARR is from the hospital, which is a 30-day exempt. Social Worker F reported a new PASAR should have been completed for R21 25 days after admission. SW F then reported a PASARR was completed today (4/17/24) and R21's diagnosis bipolar disorder was documented. R21 should have a Level II evaluation completed. In an interview on 4/17/24 at 1:36 p.m., the Director of Nursing (DON) reported the Social Worker oversees completing the PASARR's. The DON then reported the PASARR's should be reviewed on admission and if there is a need for a Level II evaluation it should be sent to the proper agency.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation, interview, and record review the facility failed to revise care plans in a timely manner for two residents (R18 and R121) out of thirty residents reviewed for care planning. Findings include: R18 During an observation on 4/17/24 at 10:25 AM, R18 had bilateral above the knee amputations and two open wounds on the bottom back side of right leg. Record review of electronic medical records revealed admission into the facility on [DATE] with pertinent diagnosis of acquired absence of right and left leg above knee. According to the Minimum Data Set, dated dated dated [DATE]. R18 had slight impaired cognition and required substantial assistance with Activities of Daily Living (ADLS). Record review of R18's Transition of Care Form dated 6/8/23, documented the following: . Primary Diagnosis: Above the knee amputation of left lower extremity. Record review of R18's active care plans revealed the following: Focus: R18 has Actual impairment to skin integrity r/t (related to) vascular ulcers to left calf, left lateral ankle, left lateral heel, and left lateral foot. Further review revealed this care plan was initiated on 5/19/23 and revised on 1/26/24. Interventions for the care plan were to be ongoing and reviewed on 7/11/24. Record review of R18's Patient Discharge Instructions dated 10/16/23, documented the following: . Discharge Diagnoses: Right foot infection; s/p (after surgery) AKA (above knee amputation). Record review of R18's active care plans revealed the following: Focus: R18 has an actual impaired skin integrity related to pressure injury. Site: R Heel Stage 2. Further review revealed this care plan was initiated on 5/19/23 and revised on 1/26/24. Interventions for the care plan were to be ongoing and reviewed on 7/11/24. Record review of R18's of care plans revealed no individualized interventions implemented regarding the two wounds observed on the bottom back side of the right leg. During an interview on 4/18/24 at 10:44 AM with the Director of Nursing (DON), it was reported that R18 had bilateral above the knee amputations and the care plans regarding previous interventions should have been revised in a timely manner and not documented as active interventions for the resident. It was further reported that R18 should have had a care plan implemented regarding the two open areas on the bottom back side of the right leg. 38230 R121 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 10:27 a.m. R121 was observed resting in bed. R121 presented as alert, oriented to person, place, and situation. Further observation revealed the resident did not have an indwelling catheter as documented as an indicator. R121 said the catheter was removed in March. On 4/18/24 at 3:36 p.m. review of the medical record documented R121 was admitted into the facility on [DATE] with diagnoses that included bladder retention and neuromuscular bladder. According to the admission MDS assessment dated [DATE], R121 was cognitively intact, required moderate assistance with activities of daily living, and was admitted with an indwelling catheter. Review of R121's care plans revealed an active care plan for an Indwelling Foley Catheter regarding to urinary retention, date initiated on 1/24/24 and revised on 2/1/24. The indwelling catheter care plan had not been resolved (discontinued). Review of the physician orders documented on 3/11/24, Please discontinue Foley catheter . Review of the facility's policy titled Care Planning dated 6/24/21 documented: Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary . Resident's will be assessed as they are admitted and readmitted to the nursing facility to determine their physical, psychological, emotional, medical and psychosocial needs. The results of interdisciplinary assessments will be used to develop, review, and revise the resident's comprehensive care plans.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 Based on observation, interview, and record review, the facility failed to implement an appropriate discharge plan to return to the community (home) for one (R79) out of three residents sampled for discharge planning, resulting in a loss of independence, unmet psychosocial needs, and support from family. Findings include: On 4/16/24 at 2:48 p.m. R79 was observed in bed resting. The resident angrily expressed wanting to know discharge plans, I have been her for two months. I'm not getting therapy. I'm not doing anything but laying here. I have everything I need at home. I keep being told I have to wait for the doctor to discharge me, but he hasn't been in here to see me. I want to go home! R79 was alert, oriented to person, place, and situation, and expressed needs and feelings. On 4/17/24 at 12:10 p.m. review of the clinical record documented R79 was initially admitted into the facility on [DATE] and readmitted from the hospital on 2/7/24 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus, and legal blindness. R79 does not have a legal representative and can make decisions independently. According to the admission and quarterly Minimum Data Set assessment (2/9/24 and 4/10/24), R79 overall goal was to return to the community. There was no active discharge planning already occurring for the resident to return to the community documented. Review of progress notes documented the following: 1/8/2024 17:39- Social Services Note . Resident was admitted to (name of facility) for rehab therapy and nursing services . Resident reports living with significant other and plans on returning home when able to . Writer will continue to follow up . 1/18/2024 14:00- Social Services Note . Discharge plan was discussed; resident will be returning to the community with significant other . 2/8/2024 08:38- Social Services Note . Resident d/c plan is to return home with husband and secondary plan is to return home with son . There were no physician orders for discharge. A discharge plan was not documented in the R79's medical record. On 4/17/24 at 1:35 p.m., Therapy Manager M was interviewed and said R79 currently was not on therapy case load, was supposed to go home once discharged from therapy, and was not certain why the discharge had not occurred, I don't know why the resident is still here. On 4/17/24 at 1:57 p.m. Social Worker F was interviewed and stated, I didn't know the resident wanted to be discharged . I was just told today. When admitted , the resident was supposed to be short term. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Discharge Planning dated 9/7/23 documented: Information: Discharge planning is started at the time of admission . Social services/ designee is responsible for driving the discharge process . Procedure: Upon admission of the resident the IDT meets with resident and/ or representative and social services documents in the medical record, the resident's discharge plan and anticipated date of discharge, if known.

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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** 38208 Based on observation, interview, and record review the facility failed to provide nail care, scheduled showers, and assist with transfers out of bed for two residents (R13 and R100) out of thirty residents reviewed for Activities of Daily Living (ADLS). Findings Include: R100 During an observation and interview on 4/16/24 at 12:57 PM, R100 was observed lying in bed with long fingernails with debris underneath nails. Resident reported that he would like his nails to be cut and cleaned. Record review of R100's Functional Ability Deficit care plan dated 12/14/23, documented Personal Hygiene-Resident is dependent. Further review of care plans and nursing progress notes revealed no preference for long nails or refusing nail care by resident in the last month. Record review of R100's electronic medical records revealed admission into the facility on [DATE] with a pertinent diagnosis of hemiplegia (paralysis of one side of body). According to the Minimum Data Set (MDS) dated [DATE], R18 had intact cognition and required substantial/ maximal assistance with most ADLs. During observations on 4/17/24 at 11:15 PM and 4/18/24 at 12:15 PM, R18 continued to have long fingernails on both hands with debris underneath nails. During an interview on 4/18/24 at 12:42 PM with Assistant Director of Nursing (ADON) I, reported that residents' nails should be cleaned and trimmed, unless it is not their preference. 39465 R13 On 4/16/2024 at 10:26 a.m. R13 was observed lying in bed alert and able to be interviewed. Observed R13 's hair unkempt and appeared greasy. R13 reported in the last three months of not being offered a scheduled shower or to get out of bed daily. It was further reported a shower instead of a bed bath would be preferred. R13 stated, I want to get up out of bed, so I don't get worse. Especially with the warmer weather, I would like to get up and go in the hallway or anywhere apart from staying in bed. Further observation revealed R13's hair with matted and had a foul odor. R13 stated, I have a knot in the back of my hair, I will have to get the knot cut out and get my hair cut short. According to the electronic medical record, R13 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses dementia, anxiety, and a history of falls. R13's quarterly Minimum Data Set (MDS) with a reference date of 1/29/2024 indicated R13 had intact cognition with a BIMS (brief interview for mental status) score of 13/15. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ADL, (Activities of Daily Living) care plan-review date of 4/29/2024 documented, R13 has a functional ability deficit and requires assistance with self-care/mobility related to fatigue/weakness. Interventions as following: -Bathing: resident requires physical help limited to transfer only. -Physical help in part of bathing activity assistance with one staff assistance to bath. -Bed mobility: Resident requires extensive assistance with one staff assistance to reposition and turn in bed. -Dressing: resident requires extensive assistance with one staff assistance to dress. -Personal hygiene/oral care: Resident requires extensive assistance with one staff assistance with personal hygiene. -Transfer: Resident requires extensive assistance with one staff assistance to transfer. R13's electronic medical record revealed no documentation of noncompliance with scheduled showers or getting up from bed to wheelchair daily. The ADL care plan did not reveal R13 preferred bed baths instead of showers. Review of a thirty days look back of R13' Scheduled Shower Task revealed, R13 scheduled shower days were Wednesday's and Saturdays on day shift. The scheduled shower task indicated R13 had missed opportunities for showers on 3/20, 3/27, 4/3, 4/10, and 4/17 of 2024. These opportunities were marked as not applicable. During an interview on 4/19/2024 at 12:02 p.m. The Director of Nursing (DON) was informed of R13's matted hair and odor, not being offered scheduled showers and not offered assistance out of bed. The DON reported that showers are scheduled twice a week. Residents should be offered a shower first and then bed baths if a resident prefers. It was further reported if a resident refuses a shower, the Certified Nursing Assistance (CNA) should notify the nurse, and they should go back and ask the resident three times to encourage the resident to take their scheduled shower. When asked what the procedure was if residents refused their scheduled showers and getting up from bed. The DON said any refusal of ADL care should be care planned and the nurses should document the refusals. The DON was asked with a shower should the resident get their hair washed. The DON said, when a resident gets a shower, washing their hair is part of the shower, if the resident refuses the shower, the resident should still have their hair combed and groomed. The DON said shower task should be documented as completed or refused, and not marked as non-applicable. According to the facility's revised 3/7/2023 Routine Resident Care policy: Resident receive the necessary assistance to maintain good grooming and personal/oral hygiene . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Guideline: Showers, tub baths, and /or shampoos are scheduled according to person centered care . additional showers are given as requested. Daily personal hygiene minimally includes assisting or encouraging resident s with washing their face and hands, shaving, nail care, combing their hair each morning. Any concerns will be reported to the nurse.

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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** 38208 Based on observation, interview, and record review the facility failed to provide adequate assessment and monitoring of wounds for one resident (R18) out of three residents reviewed for wound care management. Findings Include: During an observation and interview on 4/17/24 at 10:25 AM, R18 two open wounds on the bottom back side of right leg that measured approximately 0.5 cm (Centimeters) long and 0.5 cm wide with a depth of 0.1 cm each. Licensed Practical Nurse (LPN) G reported being made aware of wounds on 4/15/24. Record review of electronic medical records revealed admission into the facility on [DATE] with pertinent diagnosis of acquired absence of right and left leg above knee. According to the Minimum Data Set (MDS) dated [DATE]. R18 had slight impaired cognition and required substantial assistance with Activities of Daily Living (ADLS). Record review of Nurses Notes dated 4/7/24 at 12:57 PM documented the following: Note Text: Writer found two open areas to right stump. CNA (certified nursing assistant) stated these are not new wounds. Spoke to wound care, directed to apply Medi honey daily and PRN (as needed). Wound care to follow up. Further review of nursing notes revealed no documentation regarding wounds after 4/7/24. Further review of Physician orders documented orders to . Apply dressing with Medi honey daily and PRN, created 4/7/24. Further record review of EMR revealed no documentation that wounds had been assessed by wound care, measured, and monitored for decline. No care plan was initiated. During an interview on 4/18/24 at 10:26 AM with LPN G, it was reported that R18's wounds were not measured, or any documentation had been done. It was further reported that when staff find an open area it should be reported to the Director of Nursing (DON), Physician and the Wound Care Nurse. During an interview on 4/18/24 at 10:44 AM with DON. It was reported that that the wounds should have been assessed and measurements documented by the next day and assessed weekly. It was further reported, If I would have been made aware of the wounds it would have been discussed in the meeting and MDS nurse would have been made aware to update care plan. When asked if the wound care team had adequately assessed and monitored R18's wounds, DON said, No. Record review of Policy Skin Management dated 12/15/22 documented the following: . 12. If a new area of skin impairment is identified, notify the guest/resident, responsible party, attending physician, DON/designee, and treatment team, if applicable. 13.Guest's/resident's with pressure injury and lower extremity ulcers will be evaluated, measured, and staged weekly {pressure injury and vascular ulcers only) In accordance with the practice guidelines until resolved .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview, and record review the facility failed to provide vision services for one resident (R13) of two residents reviewed for assistive devices, resulting in inadequate eyewear for R13. Findings include: During an observation and interview with R13, on 4/16/2024 at 10:40 a.m., the resident was observed wearing a pair of reading glasses and holding the glasses with hand and tape on the right side of the frame (arm), while reading some literature in bed. R13 said the glasses had been broken for about two weeks and everyone knew and saw the glasses was taped up. R13 said the glasses are not prescription glasses and the reading glasses were brought in by brother from the store, because no one at the facility was assisting with getting another pair. The prescription glasses had been lost about two years at the hospital. R13 confirmed the prescription glasses were needed to see when watching television, reading and everything else. The resident further reported several requests made to social services to see the eye doctor. According to the electronic medical record, R13 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses dementia, anxiety, and a history of falls. R13's quarterly Minimum Data Set (MDS) with a reference date of 1/29/2024 indicated R13 had intact cognition with a BIMS (brief interview for mental status) score of 13/15. On 4/16/2024 at 11:16 a.m. Social Service (SS) N was interviewed regarding replacement of R13's prescription glasses. SS N said no one told her R13 needed glasses and R13 would be on the list to see the optometrist (eye doctor) on 5/10/2024. SS N confirmed that the social services department assist the residents with glasses, hearing aids etc. During an interview with the Director of Nursing (DON) on 4/19/2024 at 12:02 p.m., the DON said it's the social services responsibility to assist residents with ancillary problems.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 This citation has two deficient practices. Deficient Practice Statement 1 Based on observation, interview, and record review, the facility failed to ensure an emergency tracheostomy (an incision into the windpipe made to relieve an obstruction to breathing) was accessible, resulting in the likelihood of serious injury, serious harm, serious impairment, or death for one resident (R138) who required mechanical ventilation. In an observation on 4/16/24 at 9:55 a.m., R138 laid in bed and had a tracheostomy (trach). There was not an emergency trach visible in R138's room. In an observation and interview on 4/16/24 at 10:32 a.m., Licensed Practical Nurse (LPN) L was asked about R138's emergency backup trach and could not locate one in R138's room. LPN L reported there was not an emergency backup trach in R138's room. In an observation and interview on 04/16/24 at 10:34 a.m., the Director of Nursing (DON) was asked about an emergency backup trach for R138. The DON then searched R138's room and could not locate an emergency trach. The DON reported there should be an emergency trach in R138's room and they had to look in the storage room to locate one. On 4/16/24 at 10:50 a.m., after 18 minutes the DON located an emergency trach for R138. In an interview and observation on 4/16/24 at 10:59 a.m., the DON reported the unit manager went to get some more. A Shiley 6 trach sat on the nurse's desk and was not in R138's room. Review of an Admission Record revealed, R138 admitted to the facility on [DATE] with pertinent diagnosis which included Respiratory Failure with Hypoxia and Hypercapnia (inadequate respiration). Review of a Minimum Data Set (MDS) assessment dated of 3/23/24 revealed R138 had cognitive impairment with a Brief interview for Mental Status (BIMS) score of 0 out of 15 and required a tracheostomy. Review of a Care plan revealed R138 had focus, (R138) is at risk for respiratory distress, decannulation, infection r/t (related to) has a Tracheostomy. 6 Shiley uncuffed, tracheostomy mask at oxygen flow 2 L revised on 4/16/24. Review of Physician orders revealed R138 did not have an order that included the size of R138's trach and nothing to indicate a spare tracheostomy should be at the bedside. Review of a progress notes with a date of 4/11/2024 at 5:22 p.m., Resident sent out 911 to (hospital) d/t (due to) decannulation (removal of tracheostomy) . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a progress note with a date of 4/16/2024 at 12:00 a.m. revealed, . Follow up with ER visit due to tracheostomy dislodged . Patient is seen today for following up with ER visit due to tracheostomy dislodged. Patient's tracheostomy tube dislodged on 4/11/24 and sent patient to the ER immediately . Communicate with nurse to continue trach mask at 2 liter and contact the hospital for instruction of the new trach care and keep extra trach set at bedside . In an interview on 4/17/24 at 1:44 p.m., LPN K reported R138 had a decannulation on 4/11/24 and was sent to the hospital after the staff attempted to put another trach in but the position of head blocked the insertion. In an interview on 4/19/24 at 11:02 a.m., the DON reported on 4/11/24 R138 coughed, and the trach came out and had to be sent to the hospital because of the contracture of R138's neck. The DON reported there should have been a backup trach in R138's room. The DON then confirmed R138 did not have a current order for a tracheostomy that included size of trach, which has been changed to a size 4. The DON reported the size of the trach should be included in the order. Review of a Tracheostomy tube cannula and stoma care. Procedure with no date documented, . Make sure that the extra tracheostomy tube and obturator as well as the handheld resuscitation bag with an attached oxygen source are readily available for easy access in case of an emergency . The immediate jeopardy was identified on 4/16/24 at 9:55 a.m. The immediate jeopardy began on 4/16/24 at 10:32 a.m. when R138 was observed with a tracheostomy (trach) and did not have an emergency trach easily accessible. The Administrator was notified of the Immediate Jeopardy on 4/16/24 at 2:11 p.m. and a plan for removal was requested. The immediacy was removed on 4/16/24 when an emergency tracheostomy was placed in R138's room at the bedside. The surveyor verified that the Immediate Jeopardy was removed by observation and interview on 4/16/24. Although immediacy was removed, the facility's deficit practice was no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The Immediate Jeopardy that began on 4/16/24 was removed on 4/16/24 when the facility took the following actions to remove the immediacy: 1. R138 was provided with an accessible emergency back-up tracheostomy. 2. The Tracheostomy tube cannula and stoma care policy was reviewed and deemed appropriate. Nursing staff were re-educated on the Tracheostomy tube cannula and stoma care policy. The remaining nurses will receive education on the Tracheostomy tube cannula and stoma care policy on or before their next schedule day. 3. The DON, Administrator, and nurses made rounds on the residents with tracheostomies to ensure they have a back-up emergency equipment that is easily accessible in case of accidental extubation. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	39465 Deficient Practice#2: Based on observation, interview, and record review the facility failed to label and date an oxygen tubing for oxygen administration on a concentrator for one resident (48) out of six residents reviewed for oxygen therapy. Findings include: R48 On 4/16/2024 at 10:20 a.m., R48 was observed lying in bed with oxygen administering via nasal cannula. (The nasal cannula is a device used to deliver supplemental oxygen or increased air flow to a patient or person in need of respiratory help). Observed R48's oxygen tubing connected to an oxygen concentrator unlabeled with no date (Oxygen Concentrator s collect oxygen from the surrounding air, concentrate it, and then deliver it to the patient, removing the need for replacement or refiling). R48 unable to recall the last time the oxygen tubing was changed. On 4/18/2024 at 10:22 a.m., Licensed Practical Nurse (LPN) J was interviewed regarding oxygen tubing labeling and dating. LPN J said the oxygen tubing are changed once a week and as needed. LPN J stated, oxygen tubing should be dated, it tells me it's been changed, how long, and if it needs to be change if over a week. On 4/19/2024 at 12:02 p.m., the Director of Nursing (DON) said during an interview regarding the labeling and dating of oxygen tubing that oxygen tubing should be dated, and the importance of dating the tubing is to know how long it's been in use for cleanliness. The DON stated, The hazard of having a tubing not clean could cause a respiratory infection. According to the electronic medical record, R48 was initially admitted into the facility on [DATE] and readmitted on [DATE] with Diagnoses of pneumonia, dementia, and diabetes mellitus type two. R48 quarterly Minimum Data Set (MDS) with a reference date of 2/18/2024 indicated R48 was cognitively intact with a BIMS (brief interview for mental status) score of 14/15. Review of the 2/11/2024 Respiratory care plan revealed, Resident has a potential for difficulty breathing and risk for respiratory complications related to Asthma, Emphysema/Chronic Obstruction Pulmonary Disease (COPD), and Diaphragmatic hernia. Review of the facility's 8/17/2021 Use of oxygen policy documented, Purpose: To promote guest/resident safety in administering oxygen. The oxygen cannula or mask should be changed weekly and dated.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32000 Based on observation and interview the facility failed to maintain sanitary conditions in the kitchen resulting in an increased potential for cross contamination of food and foodborne illness, potentially affecting 143 residents who receive meal services (3 nothing by mouth residents, or NPO) out of the facility's total census of 146 residents. Findings include: 1. On 4/17/24 at between 10:15 AM, and 10:42 AM, the following non-food contact surfaces in the kitchen were observed soiled and with visible debris on their surfaces: On the ventilation filters above the fryer. On the top and sides of the fryer. On the sides of the oven next to the fryer. On the grates of the flat top grill. On the six burner oven's stainless steel backsplash. Upon observation the surveyor inquired with Dietary Director, staff A, on if they thought these areas were being cleaned timely and sufficiently to which they replied, these areas are cleaned three times a day after each meal, but it looks like we can improve on it. On 4/17/24 at 11:25 AM, the surveyor requested a copy of the kitchen's cleaning policy to review. On 4/17/24 at 11:31 AM, the number ten can opener's cutting blade at the cook prep station was observed with visible debris and metal shavings on its surface. Upon observation staff A, commented, the whole area needs to be cleaned. I'll set the can opener aside to be cleaned. On 4/17/24 between 1:09 PM and 1:33 PM, an accumulation of dust and debris was observed on the flooring throughout all the facility's nourishment rooms. At this time the surveyor inquired with staff A on if they thought the flooring was being cleaned as needed throughout the day to which they replied, not enough. At the time of the survey team's exit, no additional cleaning schedule documenting verification of the daily cleaning tasks required to be completed was received to review. Review of 2017 U.S. Public Health Service Food Code, Chapter 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, directs that: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 4/17/24 at 12:05 PM, a meal test tray was requested by the surveyor. At this time Dietary Director staff A asked the surveyor if they wanted it to be the last tray from the last serving cart to which the surveyor replied, yes. On 4/17/24 at 1:06 PM, upon taking food temperatures of the day's meal, both the surveyor and staff A observed the macaroni and cheese, and the collard greens holding at a temperature of 105 degrees F, and the fried chicken holding at a temperature of 100 degrees F. Upon observation staff C stated, I will talk to the administrator again about purchasing some additional insulated meal carts, and to fix or buy another plate warmer. We need to communicate better so these meals don't sit for too long before being served. Review of 2017 U.S. Public Health Service Food Code, Chapter 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding directs that: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401. 11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 32000 Based on observation, interview, and record review the facility failed to ensure that the garbage storage area was maintained in sanitary condition resulting in an increased potential for the harborage and feeding of pests. Findings include: On 4/18/24 at 10:27 AM, during a tour of the facility with Dietary Manager, staff A, and Cook, staff E, the exterior trash dumpsters were observed with lids in the open position, along with a variety of trash, debris, and used fryer oil surrounding the area. At this time the surveyor inquired with staff A and staff E on the current state of the area to which staff E replied, They just picked it up today, every time they dump it, it looks like this, and they leave the doors open. At this time the surveyor asked staff A if the facility had a waste disposal policy to review to which they stated, yes, I'll get you a copy. On 4/19/24 at 9:27 AM, record review of a policy dated, 4/2015, and titled, Waste Disposal revealed in item number five that, Outside dumpsters will be maintained in a clean manner. Trash will not be overflowing and lids will remain closed at all times. The trash removal company will be notified of the need for the increased service if dumpsters are consistently overflowing. Review of 2017 U.S. Public Health Service Food Code, Chapter 5-501.113 Covering Receptacles, directs that: Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (2) After they are filled; and (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT.

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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** 39958 Based on observation, interview, and record review the facility failed to follow the standards of infection control for proper PPE use (gloves), hand hygiene, and point of care testing, for one resident (R79) out of four residents reviewed for medication administration, resulting in the potential for increased cross-contamination of diseases which place a vulnerable population at high risk for infections. Findings include: In an observation on 4/18/24 at 8:14 a.m., Licensed Practical Nurse (LPN) P entered R79's room with blood glucose supplies in hand with gloved hands. LPN P placed the glucometer (used to test blood sugar levels) on R79's bed and not on a barrier. LPN P then poked R79's finger with lancet and collected blood in the glucometer strip. LPN P removed the gloves, disposed the lancet in sharps box, exited the room and did not perform hand hygiene. In an observation on 4/18/24 at 8:17 a.m., LPN P placed the glucometer in the med cart and did not clean it after use. LPN P did not perform hand hygiene after touching the glucometer. Review of an Admission Record revealed, R79 admitted to the facility on [DATE] with pertinent diagnosis which included Type 2 Diabetes. In an interview on 4/18/24 at 8:28 a.m., LPN P reported the glucometer is cleaned with an alcohol swab after each use. LPN P then reported the glucometer is cleaned with a bleach wipe at the beginning of the shift and alcohol wipe after using it. LPN P acknowledged that the glucometer was not cleaned after use and then clean it with an alcohol swab and put it back in the medication cart. In an interview on 4/18/24 at 2:20 p.m., LPN P reported hands should be washed if they are soiled and hand sanitizer should be used after glove use. In an interview on 4/19/24 at 11:57 a.m., the Director of Nursing (DON) reported the glucometer is cleaned with a disinfectant wipe after use. The DON the reported that alcohol wipes are not acceptable for cleaning the glucometer. In an interview on 4/19/24 at 1:10 p.m., the DON reported hand hygiene should be performed between residents during medication administration. The DON then reported hand hygiene should be performed after glove use. Review of a Glucometer and PT/INR (measures the time it takes for a clot to form in a blood sample) Decontamination policy revised 9/1/19 documented the following, . The glucometer & PT/INR shall be decontaminated with the facility approved wipes following use on each guest/resident. Gloves will be worn and the manufacturer's recommendations will be followed . Procedure: I. The nurse will obtain the glucometer or the PT/INR along with the wipes and place the glucometer on the overbed table on a clean surface, e.g., paper towel, foam tray or barrier surface. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. After performing the glucometer of PT/INR testing, the nurse shall perform hand hygiene, apply gloves, and use the disinfectant wipe to clean all external parts of the glucometer or PT/INR machine allowing the meter to remain wet for the contact time required by the disinfectant label. III. The clean glucometer or PT/INR will be placed on another paper towel/or barrier surface. IV. Gloves shall be removed and hand hygiene performed. V. The glucometer or PT/INR will be placed in the appropriate storage location until needed. Review of a Hand Washing policy revised 11/12/21 documented the following, employees will use correct hand washing guidelines to prevent the spread of infection.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32000 Based on observation and interview, the facility failed to ensure the 2nd floor 'wireless' nurse call light system was effectively utilized by staff or had consistently functioning centralized monitor screens on the second floor resulting in the potential for delayed call light response times, and the potential for resident care needs of 47 residents to be unmet. Findings include: On 4/17/24 at 1:36 PM, upon an environmental tour of the facility, resident room [ROOM NUMBER]'s bedside nurse call devices cord was observed frayed and taped over in two sections. At this time the surveyor tested the nurse call device at the bedside and went to the nurse's station to determine its functionality. Upon entering the nurses station, the surveyor heard no audible alarm, however the bedside nurse call device was shown flashing on a computer monitor. On 4/17/24 at 1:37 PM, upon interview with Registered Nurse, staff C, on the lack of an audible alarm being present for the nurse call system they stated, Oh, it works. We just turn the sound off because it's always going off. On 4/17/24 at 1:41 PM, upon interview with Maintenance Director, staff B, the surveyor inquired if a work order had been placed for the replacement of resident room [ROOM NUMBER]'s bedside nurse call devices cord to which they replied, I was unaware of it. I have extra and will replace it now. At this time the surveyor also inquired with staff B on if the nurse call system consisted of any wireless pagers in the building to notify the staff of a resident in need of attention to which they replied, No. It alarms at each nurses station on the computer screen and through the speakers. On 4/19/24 between 10:05 AM and 11:19 AM, upon an environmental tour of the facility with staff B the following observations were made: Upon testing of the second floors computer monitor at the 800 halls nurse's station after triggering the bedside call light in room [ROOM NUMBER], no notification was observed. The computer monitor remained black in color and no audible alarm was present. Upon observation staff B stated, it must need to be reset, this is not normal. At this time the surveyor inquired with staff B, on what the facility would normally do if the nurse call system were not functioning as designed in its originally approved condition to which they replied, we have bells we can provide to each room on each floor, but let me call IT on this first. On 4/19/24 between 10:18 AM and 10:29 AM, the surveyor then observed staff B unplugging and reattaching cords to the monitor, turning it back on and stating to the surveyor, there it is, it's back up again. It needed to be re-booted, and somehow the sound cable had gotten unplugged which is odd because of the locking tab on its connection. On 4/19/24 at 10:42 AM, the same occurrence was observed at the 500 hall's nurses' station by the surveyor and staff B. On 4/19/24 at 11:01 AM, upon the surveyor and staff B entering the 600 hall's nurse's station staff B stated, this monitor is turned off. At this time Registered Nurse, staff D, asked staff B, Does it have to stay on all day? I want it off. On 4/19/24 at 11:35 AM, a sufficient quantity of bells were observed available for use on each resident floor by the surveyor.