STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235655	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Westland	2209 N Newburgh Westland, MI 48185

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to properly assess for self-administration for eye drops for one resident (R273) out of one reviewed for self-administration of medications. Findings include: On 10/29/2024 at 12:43 PM, R273 was observed in bed. R273 stated they had just put their eyedrops in. Four bottles of eyedrops were observed on the bedside table in a bag. R273 stated they always do their own eye drops and they do not trust anyone else to do them on time for them. A review of the medical record revealed R273 admitted into the facility on [DATE] with the following medical diagnoses, Macular Degeneration and Irritable Bowel Syndrome. A review of the Minimum Data Assessment set revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition and required assistance for bed mobility and transfer. Further review of the medical record did not reveal an order, care plan, or assessment documenting R273 was able to self administer their own eyedrops. On 10/29/2024 at 3:21 PM, the eyedrops were still observed at bedside. R273 stated they had just administered them and were about to go to sleep. On 10/31/2024 at 9:15 AM, an interview was conducted with the Director of Nursing (DON). The DON stated with short term stay residents, they don't always know what they come in with. The DON stated the midnight nurse approached them, some time after admisison and told them the eye drops were at bedside and they went and spoke with the resident she determined they were able to self administer medication. The DON stated they obtained an order from the physician, completed and assessment, and entered a care plan. The DON was asked if this should have been completed on admission to which she stated the nurses would check the medication off the medication administration record (MAR) after they watched R273 administer them. A facility policy related to self administration of medications was requested on 10/30/2024 at 12:47 PM, and not received by end of survey.

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 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** 40384 Based on interview and record review, the facility failed to ensure the Preadmission Screening (PAS)/ Annual Resident Review (ARR) form for Mental Illness (MI)/ Intellectual Disability (ID)/ Related Conditions Identification (DCH-3877) document was completed and sent to the local state agency for an evaluation for a Level II determination for two residents (R11 and R74) of four residents reviewed for PASARRs. Findings include: R74 On 10/29/24 at 9:42 AM, R74 was interviewed in their room regarding their stay in the facility, and indicated they are a Veteran, and was a prisoner of war for 55 months, and as a result, suffers from nightmares every night. A review of R74's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Traumatic Subdural Hemorrhage, Diabetes, Hypertension, and Muscle Weakness. Further review of R74's medical record revealed they had a moderately impaired cognition, and required partial to moderate assistance for transfers and mobility. Further review of R74's medical record did not reveal a PASARR Level I screening completed by the facility. On 10/30/24 at 2:43 PM, Social Worker A was about R74's Level I screening, and she indicated she would investigate it and get back to surveyor. On 10/30/24 at 3:18 PM, Social Worker A returned and explained there wasn't a Level I screening completed by the facility for R74, and there should have been one completed. 49102 R11 On 10/29/24 at 9:35 AM, R11 was observed lying in bed watching television in their room On 10/29/24 at 12:51 PM, R11 was observed lying in bed with a sad facial expression and holding their head. R11 stated , my head hurts. On 10/30/24 at 1:00 PM, R11 was observed lying in bed. A half eaten lunch tray was visible on tray table. R11 stated there were no concerns today and was watching television. A review of R11's medical record revealed they were admitted into the facility on [DATE]. R11 has diagnose of Dementia, Psychotic disturbance, Mood disturbance, Psychotic disorder with delusions and Schizoaffective disorder. A review of the most recent Minimum Data Set assessment dated [DATE] was completed with a Brief Interview for Mental Status (BIMS) score of 3 indicating severely impaired cognition. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R11's medical record did not reveal an Annual PASARR Level I screening had been completed by the facility. On 10/31/24 at 1:45 PM, Social Worker A was interviewed about R11's updated PASARR screening. Social worker A they would investigate it and get back to surveyor. On 10/31/24 at 2:20 PM, Social Worker A returned and explained there was not an updated 3877 for R11, and there should have been one completed. A review of the policy titled, Pre-Admission Screening and Guest/Resident Review - PASRR Michigan dated 12/01/2017 and last revised 11/12/2021 revealed The PASRR process was established in 1987, as part of the OBRA ruling, to screen all individuals admitted for nursing care to ensure that needs are met to assist the individual in reaching their highest potential. All persons seeking admission to a nursing facility, who are seriously mentally ill and/or have an intellectual/developmental disability, are required to be evaluated to determine if a nursing facility is the appropriate place to receive services. Additionally, a Level 1/3877 is completed annually for all guests/residents and maintained in the electronic medical record. For those who screen positively for a mental illness/intellectual/developmental disability the facility submits the annual Level 1/3877 screen to the local community mental health program for comprehensive screening (Level 2).

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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** 40384 This citation has two Deficient Practice Statements. Deficient Practice Statement #1 Based on interview and record review the facility failed to follow a physician's order for a urology consult for one resident (R74), of one reviewed for physician orders. Findings include: On 10/29/24 at 9:42 AM, R74 was interviewed in their room about the care they are receiving in the facility. R74 explained they have been having pain during urination which causes burning sensations. R74 explained they have been feeling like this for weeks and nothing has been done. A review of R74's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Traumatic Subdural Hemorrhage, Diabetes, Hypertension, and Muscle Weakness. Further review of R74's medical record revealed they had a moderately impaired cognition, and required partial to moderate assistance for transfers and mobility. Further review of R74's medical record revealed a physician's order dated for 8/7/24 for the following, Urology (for issues related to urtinary tract, kidneys or prostat) consult for continued symptoms of BPH (benign prostatic hyperplasia, a noncancerous increase in size of the prostate gland) on dual therapy. Further review of the order revealed that it was, completed. On 10/30/24 at 9:18 AM, R74 was observed in their room, and asked about their symptoms, and they explained they are still having concerns with burning during urination. On 10/30/24 at 9:56 AM, R74's urology consult was requested from the facility, and they responded with the following, .[R74] doesn't have any orders for urology consults. [R74] has neurology (for issues related to nerves), but not urology. A review of R74's progress notes revealed the following: 8/5/2024 00:00 Progress Notes Date of Service: 8/5/2024, Visit Type: Acute: Pt (patient) reports difficulty urinating and dysuria (painful urination) . states he has not seen urology. Previous UA's (urinalysis) were insufficient/rejected. UA with reflex C&S (culture and sensitivity) ordered. There is not a bladder scanner available per nursing. Will order urology consult for continued symptoms on dual therapy . On 10/31/24 at 10:00 AM, an interview was completed with the Director of Nursing (DON) regarding R74's urology consult. She explained she would look into it however, there was no additional information received prior to survey exit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Physician's Orders policy did not address physician orders not being followed. 44750 Deficient Practice Statement #2 Based on observation interview, and record review, the facility failed to ensure transportation to outside appointments for one resident (R270) out of three reviewed for outside appointments. Findings include: On 10/29/2024 at 10:30 AM, an interview was conducted with Family Member (FM) F. FM F stated they were unhappy with the care being provided for R270. FM F stated R270 has missed 3 out of four follow up appointments set up by the hospital while in facility due to transportation errors by the facility. FM F stated they were told R270 must go by stretcher because they are on Total Parenteral Nutrition (TPN - receiving all nutrition through a tube). FM F stated they missed an Endocrinologist appointment on 10/23/2024 due to them needing a stretcher instead of wheelchair, a cardiologist appointment on 10/28/2024 due to transportation having an emergency, and 10/29/2024 because they never showed up. FM F stated the last two appointments were for the Cardiologist. FM F stated they don't understand why they don't use a different transportation company. A review of the medical record revealed R270 admitted into the facility on [DATE] with the following diagnoses, Muscle Weakness and Disease of Pancreas. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score revealed a Brief Interview for Mental Status score of 9/15 indicating an impaired cognition. R270 also required staff assistance for bed mobility and transfers. On 10/30/2024 at 12:04 PM, an interview was conducted with [NAME] Clerk (WC) H. WC H stated they believe that FM F gave them the follow up appointments from the hospital and they made the transportation. FM F stated FM F originally stated R270 could go in a wheelchair, however they were unable to because of the TPN so they had to order transport that could accomodate a stretcher. WC H confirmed they were unaware if the appointment had been rescheduled or not. WC H stated R270 missed their other two appointments due to transportation running late and then not showing up. On 10/31/2024 at 9:20 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they have six companies they use for transportation and were in the process of looking for alternative companies to take R270 to their appointment. A review of a facility policy titled, Social Service Referrals to Outside Providers did not address transportation.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 Based on observation, interview, and record review, the facility failed to ensure restorative care and splint application was documented and services provided for three residents (R38, R47, and R76) of four reviewed for restorative services. Findings include: R38 On 10/29/24 at 11:09 AM, R38 was observed to be seated in a wheelchair next to their bed. R38 appeared to have the fingers of their right hand in a fixed position. A hand or wrist splint was not in place or visible in the room. On 10/30/24 at 1:04 PM, the therapy course for R38 was reviewed with Physical Therapy Assistant B. It was reported that R38 had not been on service since March of 2023 and was on the physical therapy caseload only at that time. A therapy screen conducted 10/12/24 indicated no change in status. On 10/30/24 at 2:36 PM, the restorative history of the identified resident was reviewed with Restorative Licensed Practical Nurse (LPN) C who reported R38 was discharged and not on the current caseload and reported restorative and assigned staff are able to apply a splint. A review of the record for R38 revealed: R38 was admitted into the facility on [DATE]. Diagnoses included, Muscle Weakness, Difficulty Walking, Dementia and Alzheimer's. The active Kardex (care guide) documented R38 was dependent on one staff to roll right and left in bed, and lying to sit on the side of bed and to go from sitting to lying. A review of the active tasks in the electronic medical record (EMR) documented, .to wear right wrist hand finger orthosis 3-4 hours a day as tolerated .(R38) may remove for (their) own comfort. A review of the task documentation for the task Was the resident's splint applied per the maintenance splint program revealed just one entry which was dated for 10/09/24 and which indicated not applicable. A review of the physical therapy discharge note dated 04/01/24 revealed: .RNP/FMP (Restorative Nursing Program/Functional Maintenance program) to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT (interdisciplinary team): ROM active (range of motion), Omni cycle . R47 On 10/29/24 at 11:21 AM, R47 appeared to be resting in bed with the head of bed up. A walker and a wheelchair were observed to be in the resident's area. A review of the record for R47 revealed, R47 was admitted into the facility on [DATE]. Diagnoses included Difficulty Walking and Need for Assistance with Personal Care. The active care plan initiated 06/27/24 documented impaired visual function, bowel and bladder incontinence related to impaired mobility, at risk for falls and R47 required partial/moderate assistance for bathing, dressing, personal hygiene and toilet transfer. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physical therapy discharge note dated 09/05/24 and revised 09/11/24, revealed, .RNP/FMP to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT: ROM active and ambulation . An occupational therapy discharge note dated 09/06/24 and revised 09/11/24 documented, .referred to restorative . On 10/30/24 at 2:36 PM, the restorative history of the identified resident was reviewed with LPN C who reported R47 was on the current caseload. A progress note dated 10/30/24 at 2:59 PM and at 5:25 PM by LPN C noted R47 had refused and reported R47 said they have an 'accident' when they exercise and did not want to have an accident. No further refusals were noted or documentation provided. R76 On 10/29/24 at 12:56 PM, R47 was observed to be seated in dining room in a high back wheelchair, assisted/encouraged to eat by staff. R76 was observed to feed themselves. A splint was not observed. On 10/29/24 at 1:36 PM, R76 was on the common area of their unit seated in a high back wheelchair their legs elevated. A splint was not observed. On 10/30/24 at 11:20 AM, R76 was observed up in a wheelchair in the activity area. The footrest was elevated around 90 degrees and the legs of R76 extended straight out. R76 appeared to have a foot drop type of contracture and appeared to be asleep. A splint was not observed. On 10/30/24 at 1:10 PM, PTAB reported R76 was evaluated by therapy for their left elbow in August of 2024 and had been the therapy caseload May 2024 to July 2024 for the left upper extremity. On 10/30/24 at 1:55 PM, R76 continued to be seated in a high back wheelchair with their feet more flat on foot rest which was angled down. A splint for the elbow and hand were not observed. On 10/31/24 at 8:16 AM and 9:16 AM, R76 was observed to be in bed, asleep. A splint was not observed to be visible in the resident area nor applied to the resident. A review of the record for R76 revealed R76 was admitted into the facility 09/23/22. Diagnoses included Paralysis of the left side, Abnormalities of Gait and Mobility and Age related Physical Debility. A review of the active care plan documented, impaired cognition, bowel and bladder incontinence. A revision of the care plan dated 02/09/24 documented substantial/maximal assistance was required for bathing, dressing, bed mobility and personal hygiene. A review of the occupational therapy evaluation dated 08/08/24 revealed, .referred to OT for left elbow contracture .(left) elbow contracture brace obtained and donned on pt (patient) good fit and comfort noted by writer and (patient) . The note also documented R76 was dependent for toileting hygiene, dressing and bathing. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the order for restorative nursing with date imitated of 10/08/24 revealed, Nursing Rehab: Left elbow contracture splint and WHFO (wrist hand finger orthosis) to be worn at night or as tolerated to prevent contracture and optimize ADL (activities of daily living) functioning. A review of the active tasks revealed no entries had been documented for the task amount of time spent providing nursing rehab service nor that care was provided for the Left elbow contracture splint and WHFO to be worn at night or as tolerated to prevent contracture and optimize ADL functioning. On 10/31/24 at 9:08 AM, restorative concerns related to missing documentation were reviewed with the Director of Nursing (DON). The DON acknowledged the missing documentation. The DON reported they were not aware of any time in the last thirty days where the restorative staff had to work the regular floor. On 10/31/24 at 9:23 AM, LPN D confirmed R47 participated in therapy and does more when family is present. LPN D also reported they had seen R76 wear a splint a while back but had not worn it in a minute and was not always cooperative. On 10/31/24 at 9:36 AM, Certified Nursing Assistant (CNA) E reported they had not seen R47 with restorative not R38 with a splint in the last thirty days. CNA E reported R38 will tell you what they want. The most recent restorative documentation for R38, R47, and R76 was requested on 10/30/24 at 3:02 PM. Additional documentation was not received prior to survey exit. A review of the facility policy titled, Restorative Nursing revised 04/26/24 revealed, .Components of the restorative nursing program include, but are not limited to the following: .Referral from skilled therapy services via the Therapy to Restorative Program Plan .During weekly Interdisciplinary Team Meeting . Morning clinical meeting. Completion of the Restorative Initial Evaluation if placed on a Restorative Program. Development of measurable goals and individualized interventions for a specific restorative program Evaluation of progress towards goals and effectiveness of interventions. Interdisciplinary process to identify when a resident is appropriate to discharge from restorative nursing . 6. Document any refusal in the resident's medical record . 11. Document the resident's daily participation and actual number of minutes participating in in the resident's {electronic health record} EHR . 12. The licensed nurse will meet with the restorative aide(s) or nurse aide(s) to evaluate and document the effectiveness of interventions periodically but, at least quarterly .

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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. 32220 This citation pertains to Intake MI00146972. Based on observation, interview, and record review, the facility failed to ensure spoiled food items were discarded, open food items dated when opened, and cooking utensils were clean when stored, potentially affecting all 115 residents at risk for food borne illnesses. Findings include: On 10/29/24 at 9:41 AM, a review of the kitchen with the dietary manager revealed: -dust build up on top of the ovens; -a prepared salad in the chef's refrigerator was dated 10/18/24 with the salad items wilted and appeared moldy; -a package of sliced american cheese was open and not dated; -three scoops/strainers with dried food debris or white and opaque dried liquid stains; -in the walk-in freezer chocolate chip cookie dough were open to air, chicken chunks were open to the air and the bags were not dated; -in the freezer turkey patties were open to the air; -in the walk-in refrigerator a package of sliced cheese had a black mold like growth on multiple slices; -a box of whole green peppers had at least five peppers with a green mold or wilted areas. The identified concerns were reviewed with the Dietary Manager who reported the staff are trained to rotate the stock in the walk-ins (refridgerators). A review of the facility policy titled, Food Purchasing and Storage dated 11/11/21 revealed, .Space will be allowed on all sides of shelving to permit ventilation .Leaking or spoiled items will be discarded .Containers with tight fitting covers or sealed plastic bags will be used for storing foods that have been removed from their original container .Opened dry items, such as pasta, rice, and crackers will be stored, labeled, and sealed .Perishable Storage Facilities: The shelving will be adequate to allow air circulation around the foods. Foods will be stored so there is no contamination from items stored above 5. Perishable Food Storage: Food stored in the refrigerator or freezer will not be overcrowded, allowing adequate air circulation . All food items in refrigerators will be properly dated, labeled, and placed in containers with lids, will be wrapped, or stored in sealed food storage bags . All frozen food will be dated, labeled and wrapped or sealed. Moisture-proof, tight-fitting materials will be used to prevent freezer burn .