STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235657	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Canton	45900 Geddes Road Canton, MI 48188

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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** 34901 Based on observation, interview, and record review, the facility failed to complete an assessment for the self-administration of medication for one resident (R51), out of 40 residents reviewed for medication administration, resulting in the potential for inappropriate medication administration. Findings include: On 6/11/24 at 9:30 AM, Resident #51 (R51) was sitting on the side of his bed. An overbed table was in front of the resident as he was eating breakfast. R51 said a podiatrist did minor surgery on his toe. A 30 cc (cubic centimeter) cup with white cream was observed on the overbed table. When queried about the contents, R51 stated, It's a pain lotion. I put it on myself. On 6/11/24 at 9:39 AM, Licensed Practical Nurse (LPN) K indicated she was the nurse for R51. R51's medications were reviewed with LPN K, and R51 had a prescription for diclofenac sodium topical gel 1%. This medication was to be applied to left foot topically three times a day for pain. LPN K said R51 puts the medicated lotion on his toe himself. LPN K acknowledged that R51 did not have a physician's order to self-administer the medicated lotion. LPN K stated, He wants to do it himself. When queried if it was right for R51 to administer the medication himself without a physician's order, LPN K stated, No. A review of R51's clinical record documented an initial admission to the facility on [DATE] and readmission on 8/28/23. R51's diagnoses included diabetes mellitus-type 2, peripheral vascular disease, and acquired absence of left toe(s). A Minimum Data Set assessment dated [DATE] documented moderate cognitive impairment. There was no care plan for self-administration of medication in R51's clinical record On 6/13/24 at 10:51 AM, the Director of Nursing (DON) said the nurse should have applied the (medicated) cream because of the physician's order. A review of the facility policy titled, Medication Administration, dated 10/17/23, documented in part the following: Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with the guideline for self-administration of medication. A self-administration evaluation will be completed prior to the resident starting the self-administering process. Self-administration of medication will be reflected in the resident care plan along with any special considerations. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 3:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to notify the physician of an acute change in condition for one resident (R152). Findings include: A review of the clinical record revealed Resident #152 (R152) was initially admitted to the facility on [DATE] and readmitted on [DATE]. R152's diagnoses included chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, hypertension, congestive heart failure (CHF), and gastro-esophageal reflux disease. A Minimum Data Set assessment dated [DATE] documented intact cognition. On 6/13/24 at 10:55 AM, when a review of R152's clinical record was conducted with the Director of Nursing (DON), the following was noted: 1. Nurse progress note dated 4/7/24 at 12:57 PM: Resident refusing food and pills this AM. Requested to go to the hospital r/t (related to) stomach pain. 2. According to the April 2024 Medication Administration Record for R152, 9:00 AM medications refused by on 4/7/24 included: Bupropion (for depression), Duloxetine (for depression), Furosemide (for CHF), Lisinopril (for hypertension), Vesicare (for overactive bladder), Diclofenac (for pain), Metformin (for diabetes), Gabapentin (for neuropathy), and Mylanta (for indigestion). 3. Review of an eINTERACT Change in Condition Evaluation, dated 4/7/24 at 1:03 PM for R152 documented in part the following: - Signs & symptoms identified: Abdominal pain. Started on 4/6/24 at night. - Mental status evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) - Description of respiratory changes: labored or rapid breathing - Abdominal/GI status evaluation: Abdominal pain. Abrupt onset of severe pain or distention, OR with fever, vomiting. Acute on chronic abdominal pain. - Summary of observations, evaluation and recommendations: Resident refusing food and pills this AM. Requested to go to the hospital r/t stomach pain. - Were the change in condition and notifications reported to primary care clinician? No - If no, please explain: Resident requested to go to the hospital. 4. There were no nursing progress notes generated on 4/6/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After R152's record review, the DON agreed that something acute was going on with R152. The DON said, I don't see that the physician was notified. The physician needs to be informed of any change in resident's condition and of the resident's request (to go to the hospital). The DON added that when R152 refused her 9:00 AM medications on 4/7/24, We should have notified the physician. A review of the facility policy titled, Notification of Change, dated 2/14/24, revealed in part the following: - The facility must inform the resident; consult with the resident's practitioner .when there is a change in status. - A change in status would include .a decision to transfer or discharge the resident from the facility. On 6/13/24 at 3:00 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview, and record review the facility failed to administer a transdermal patch in accordance with the manufactures guidelines and physician's orders for two residents (R211 and R257) out of forty residents reviewed during medication administration, resulting in the potential for excessive medication dosage delivery and inadequate pain relief. Findings include: R211 On 6/12/2024 at 09:18 a.m. Medication Administration (Med Pass) for R#211 was performed with Licensed Practical Nurse (LPN) R. During the med pass, LPN R was informed by R211 that a right hip Lidoderm patch was not applied on 6/11/2024. LPN R observed a Lidoderm patch dated 6/11/2024 on R211's left hip. LPN R said the Lidoderm patch was put on the wrong hip. LPN R removed the left hip Lidoderm patch and placed another Lidoderm patch on R211's right hip. LPN R was asked was the physician's order written for the Lidoderm patch to be placed on the right hip. LPN R stated, Yes, the Lidoderm patch should have been on the side the resident was having pain. It was the nurse from yesterday (6/11/2024) that put it on the wrong hip. According to the electronic medical record, R211 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses of gout and end stage renal disease. R211's admission Minimum Data Set Assessment (MDS) with a reference date of 3/28/2024 indicated the resident's cognition was intact with a BIMS (brief interview for mental status) score of 13 out of a possible score of 15. Review of the physician order documented, Lidoderm External Patch 5%: Apply to right hip topically every twenty-four hours for pain on for twelve hours: off for twelve hours with a start date of 6/8/2024. On 6/13/2024 at 2:15 p.m., during an interview the director of Nursing (DON) was informed of R211's Lidoderm patch observed on the wrong hip. The DON confirmed the Lidoderm patches should have been applied as ordered. R257 On 6/12/2024 at 09:30 a.m. medication pass for R#257 was performed with Licensed Practical Nurse (LPN) Q. LPN Q reviewed the Medication Administration Record (MAR) for R257's Lidoderm Patches removal and application times. LPN Q said the patch was to be removed at 8:59 a.m. and applied to the right shoulder and right hip at 9:00 a.m. LPN Q was asked were the time of removing the patches one minutes apart. LPN Q confirmed the removal times documented on the MARs was correct. LPN Q was asked for the Lidoderm Patch Manufacture instructions. When LPN Q read the Lidoderm Patch manufacture instructions, the following was documented, Apply the Prescribed number of patches on once for up to twelve hours within a twenty-four-hour period. Remove patches if irritation occurs. LPN Q stated. It should stay on for twelve hours not almost twenty-four hours, I am glad you caught that. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/2024 at 9:50 a.m. during an interview, Unit Manager/Licensed Practical Nurse (UM/LPN) S confirmed R257's Lidoderm Patches should have been removed at 9:00 p.m. and applied at 9:00 a.m. UM/LPN S stated, The patches should be on for only twelve hours; I will follow up on it. On 6/13/2024 at 2:15 p.m., during an interview the Director of Nursing (DON) was informed of the inaccurate documented times of R257's Lidoderm patches removal and application. The DON confirmed that Lidoderm patches should only be left on for twelve hours and should have been removed at 9:00 p.m. and written on the MAR accordingly to those times. According to the electronic medical record, R257 was admitted into the facility on [DATE] with diagnoses of aged-related osteoporosis and chronic kidney disease. R257's admission MDS with a reference date of 6/4/2024 indicated the resident cognition was intact with a BIMS score of 13 out of a possible score of 15. Review of the physician order documented, Lidoderm Patch 5%: Apply to right shoulder and right hip topically in the morning for pain and remove per schedule with a revision date of 6/12/2024. According to the facility's revised date 10/17/2023 Medication Administration policy: Resident medications are administered in an accurate, safe, timely and sanitary manner. Physician's orders: Medications are administered in accordance with written orders of the attending physician.

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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** 47964 Based on observation, interview, and record review the facility failed to provide audiology services for one of one resident (R65) reviewed for hearing concerns, resulting in inadequate accommodations of hearing needs. Findings include: On 6/12/24 at 8:46 am R65 was observed in bed eating breakfast. When R65 was asked about conditions in the facility she replied, I can't hear you can you speak up? R65 was asked do you have hearing aids R65 replied I still can't hear you. There were no hearing devices observed in R65's room. Record review of the Electronic Medical Record (EMR) revealed R65 was admitted into the facility on [DATE] with diagnoses that included unspecified hearing loss bilateral, cochlear implant status and history of falling. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R65 had severe cognitive impairment. The assessment also documented R65 had moderate difficulty hearing and had no hearing aids. Record review of the care plan dated 4/2/24 revealed in part . Focus: R65 has impaired communication as evidenced by hearing deficit, having to repeat words, Goal: will maintain communication by hearing devices, Interventions: Refer to Audiology for hearing consult as ordered. There were no audiology consults to review in the medical record. There were no physician's orders for an audiology consult in the medical record. On 6/12/24 at 3:25 p.m. Social Worker A was interviewed and said R65 was not referred to see the audiologist, so no consults were available for review. Social Worker A also said the process for hearing referrals are as follows: a consent is first obtained by the resident or legal guardian, then sent to the ancillary service provider. A physician's order is also obtained. Once the referral is sent to the ancillary service provider then residents are put on the list to be seen on the next visit. Social Worker A stated, The previous Social Worker left in April so R65 was not referred to the audiologist. On 6/13/24 at 9:30 a.m. the Director of Nursing (DON) was interviewed and said the Social Worker is responsible for facilitating audiology services and agreed R65 should have been referred to audiology services. Review of the facility's policy titled Social Services Referral to Outside Providers last revised 10/27/2023 revealed in part .Referrals to ancillary providers will be made to meet the psychosocial and/or concrete needs of a resident. Social services make a referral to the outside service and provides demographics and signed consent, as needed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on observation, interview, and record review, the facility failed to: 1. Ensure the dishmachine was in good working order; 2. Ensure pans and lids were properly cleaned and allowed to air dry before stacking; 3. Ensure the floor of the walk-in cooler was cleaned. 4. Store a plastic crate containing cartons of milk on a clean floor; 5. Ensure expired food was not stored with active food stock; 6. Properly date-label food stored in the walk-in cooler, walk-in freezer, and resident refrigerators; 7. Ensure proper cooling of cooked, potentially hazardous (time-temperature for safety) food, goulash and sausage gravy; and 8. Ensure staff food was not commingled with residents' food. These deficient practices had the potential to affect all the residents who consumed food from the kitchen, resulting in the potential for food-borne illness. Findings include: On [DATE] at 7:25 AM, during the initial tour of the kitchen with Dietary Manager (DM) B the following was observed: The temperature log for the dishmachine did not have an entry for [DATE]. DM B acknowledged that the temperatures of the dishmachine wash water and rinse water had not been obtained prior to washing kitchen items, a drinking glass, two knives, a green handled portion scoop, and an eight-quart clear plastic food container, that were drying on a rack on the dishmachine draining board. DM B said they use a high-temperature dishwasher, and they should have obtained water the temperatures before using it. DM B ran a dishwasher temperature label through the dishmachine two consecutive times. The indicator panel on the temperature label was to turn black when the wash and rinse temperatures reached the correct temperature to clean and sanitize kitchenware and tableware. Neither test strip turned black. DM B said he will request a technician service call from the company that services and repairs the dishmachine. The following was observed stored in the clean pot/pan area: - Three 16 x 24 sheet pans nestled together were wet and soiled with food debris. - Five clear storage container lids nestled together were soiled with coffee stains. The following was observed in the walk-in cooler: - A milk crate full of eight-ounce carton of milk was store on the floor. DM B said nothing should be on floor in walk in cooler. - An open bag of mozzarella cheese with a use-by-date of [DATE]. - A box of cheese manicotti shells with two of the shells uncovered in the box. - A sixth-size steam table pan containing a red sauce. The sauce was uncovered and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Two 16.9 ounces of carbonated beverages. DM B said the pop belonged to staff. - The floor of the walk-in cooler was stained and soiled with debris. The following was observed in the walk-in freezer: - An opened package containing three pounds of uncooked sausage was not labeled with opened and use-by dates. - A full undated eight-quart container of goulash. - A half-full undated eight-quart container of sausage gravy. When asked for the cooling logs for the goulash and sausage gravy, DM B said they were not done. During a return visit to the kitchen on [DATE] at 3:05 PM, Cook E ran a dishwasher temperature label through the dishmachine. The temperature indicator panel did not turn black. On [DATE] at 3:15 PM, the dishmachine service technician, (Tech I) performed diagnostic tests on the dishmachine and determined that one of the heating elements for the dishmachine was not working and needed to be replaced. Additionally, the main power switch to the dishwasher booster heater had been turned off. On [DATE] at 9:40 AM, the following was observed in the Cherry Hill nourishment refrigerator: - two unopened snack meal kits containing meat and cheese. The meal kits were not labeled with a resident name. On [DATE] at 9:45 AM, the following was observed in the [NAME] nourishment refrigerator: - one unopened loaf of cinnamon bread. The loaf of bread was not labeled with a resident name. A review of the facility policy titled, Dish Machine Usage and Sanitation, dated [DATE], documented in part the following: - The Culinary staff will check the temperatures on a High Temperature Dish Machine for proper sanitation, using the machine Wash and Rise Gauges, before washing dishes. - In addition to recording the gauge temperatures, the Culinary staff will check the calibration of the gauges per Manufacturers' recommendations prior to washing dishes by using a commercial temperature test strip. - Corrective action will be taken immediately if . there is inadequate Wash or Rise Temperatures. - Minimum Wash Temperature ,d+[DATE] F (according to the type of dish machine, as defined by manufacturers' instructions; and Final Rinse Temperature must be at least 180 F. According to the 2013 FDA Food Code: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Section ,d+[DATE].11, entitled, Safe, Unadulterated, and Honestly Presented, was reviewed and revealed, Food shall be safe, unadulterated, and, as specified under S ,d+[DATE].12, honestly presented. - Section ,d+[DATE].11 Food Storage. Pressurized beverage containers, cased food in waterproof containers such as bottles or cans, and milk containers in plastic crates may be stored on a floor that is clean and not exposed to floor moisture. - Section ,d+[DATE].14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 135 F to 70 F; and (2) Within a total of 6 hours from 135 F to 41 F or less. - Section ,d+[DATE].11, Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts ,d+[DATE] and ,d+[DATE]. - Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. - Section ,d+[DATE].12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. On [DATE] at 3:00 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information when asked.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to ensure wound treatments were consistently documented per physician orders and nursing standards of practice for treatment administration for one resident (R3) of three residents reviewed for skin conditions, resulting in the potential for compromise and complications in health. Findings include: A review of the clinical record documented Resident #3 (R3) was initially admitted to the facility on [DATE] and readmitted on [DATE]. R3's diagnoses included schizophrenia, epilepsy, cerebral infarction, and hemiplegia. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. Wound note of 5/2/24 documented left 1st digit (hallux-great toe) wound size as 0.7 cm (centimeter) x 0.2 cm. Wound note of 6/8/24 documented left 1st digit wound size as 0.7 cm x 0.5 cm. Review of R3's care plans documented the following: - (R3) is at risk for skin integrity/pressure injury related to: decreased cognition, incontinence, decreased independent mobility, left side hemiplegia, limited turn sites, contractures bilateral upper extremities and lower extremities. Revised on 5/3/22. - Vascular wound tip of left great toe. Dated 4/13/24. Interventions included: - Follow facility policies/protocols for the prevention/treatment of impaired skin integrity. Dated 6/29/20. - Treatment per order. Dated 4/13/24. On 6/13/24 at 1:20 PM, a review of R3's physician's orders and Treatment Administration Records (TAR) with the Director of Nursing (DON) revealed that wound care was not documented on the TARs as follows: - Clean with normal saline. Dry and apply antifungal powder under left arm and inside the palm of left hand. Dated 1/2/24. Day administration not documented: 5/8/24, 5/13/24, 5/18/24, 5/19/24, 5/23/24, 5/24/24, 5/27/24, 5/29/24, 6/2/24, 6/6/24. Night administration not documented: 5/2/24, 5/6/24, 5/7/24, 5/8/24, 5/9/24, 5/11/24, 5/12/24, 5/15/24, 5/16/24, 5/27/24, 5/30/24, 6/3/24, 6/4/24, 6/5/24, 6/9/24. - Cleanse buttocks with soap and water. Apply Z Guard (used to treat and prevent minor skin irritations), cover with foam dressing every night shift for popped blister. Dated 7/12/23. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Night administration not documented: 5/2/24, 5/6/24, 5/7/24, 5/8/24, 5/9/24, 5/11/24, 5/12/24, 5/15/24, 5/16/24, 5/19/24, 5/27/24, 5/29/24, 5/30/24, 6/3/24, 6/4/24, 6/5/24, 6/9/24. - Cleanse left great toe (big) with normal saline, apply medihoney (wound care gel) and border gauze every shift and prn (as needed) every shift. Dated 4/4/24. Day administration not documented: 5/8/24, 5/13/24, 5/18/24, 5/19/24, 5/23/24, 5/27/24, 5/29/24, 6/2/24, 6/6/24, 6/7/24. Night administration not documented: 5/1/24, 5/2/24, 5/6/24, 5/7/24, 5/8/24, 5/9/24, 5/11/24, 5/12/24, 5/15/24, 5/16/24, 5/19/24, 5/20/24, 5/24/24, 5/27/24, 5/29/24, 5/30/24, 6/3/24, 6/4/24, 6/5/24, 6/9/24. The DON stated, The nurses should have documented (on the TAR) even if they (the resident) refused. A review of the facility policy titled, Documentation Expectations, dated 6/21/23, revealed in part the following: - Chart events as they occur and maintain chronological order. - An electronic medication/treatment administration record is utilized, nurse initials, omissions, or other documentation relating to the administering of a medication/treatment will be documented in an electronic format per the electronic format per the electronic medication/treatment administration record software. On 6/13/24 at 3:00 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information when asked.