STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235658	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Bluffs Park	355 Huron View Blvd Ann Arbor, MI 48103

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review the facility failed to maintain the dignity for 2 (Resident # 42 and 50) of 2 residents reviewed resulting in anger, frustration and the potential for decreased self worth. Findings include: Resident #42 Review of the Face Sheet revealed Resident #42 (R42) was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included multiple fractures of ribs, muscle weakness, orthostatic hypotension (drop in blood pressure upon standing), hemiplegia and hemiparalysis following cerebral infarction affecting non dominant left side (weakness and/or total loss of function on left side of body after experiencing a stroke), bilateral chronic angle closure glaucoma (bulging of the iris resulting in fluid and pressure build up in the eye), and bilateral blepharitis (inflammation of the eyelids). Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/24 revealed R42 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The Care Plan reflected R42 required partial/moderate assistance with (one, helper(s) and walker, supervision with wheelchair) for ambulation and one assist for toileting. On 4/23/24 at 10:42 AM, during an observation of a neighboring resident room, Staff Member (SM) E was observed in the doorway of R42's room to assist in answering her call light. R42 was seated at the end of her bed with her bedside table in front of her. SM E asked R42 if she needed to use the bathroom. R42 responded with bathroom and then proceeded to continue speaking in another language. SM E stated to R42 please speak English. R42 again attempted to communicate with SM E in a different language. SM E stated that she would let someone know that R42 had to use the bathroom. R42's call light was turned off and SM E exited the area. Resident #50 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Face Sheet revealed Resident #50 (R50) was admitted to the facility on [DATE] with diagnoses that included diffuse large b-cell lymphoma, muscle weakness, and need for assistance with personal care. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/3/24 revealed R50 scored 9 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). In an observation and interview on 04/23/24 at 3:21 PM, R50 was observed in his bed watching television. R50 was easily conversant, understood questions and answered appropriately. R50 reported having concerns with call light response time. R50 stated that he has to wait up to an hour for his call light to be answered and at times, his call light is not in reach. R50 reported more recently on 4/22/24 after dinner, he did not have his call light and required staff assistance. He stated the only was to notify staff was to yell out for help. R50 reported hearing a group of staff in the hall talking so he yelled out can someone come help me? R50 stated that after yelling out a few times, one of the staff members in the hallway replied no and he could hear them laughing afterward. R50 stated that it made him feel frustrated and worthless.

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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 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** 46954 Based upon observation, interview and record review, the facility failed to provide repair services for a power wheelchair in a timely manner for one (R19) of one residents reviewed for adaptive equipment, resulting in resident dissatisfaction and reduced resident independence with wheelchair mobility. Findings Include: Review of the Face Sheet revealed Resident #19 (R19) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included difficulty in walking, shortness of breath, repeated falls, and paralytic gait. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/3/24 revealed R19 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Care Plan revealed R19 required assistance of one staff member for toileting and the use of a hemi walker. On 04/23/24 at 2:59 PM, R19 was observed in her room watching television. R19 was seated in a standard wheelchair. A power wheelchair was observed in the corner of the room. When queried about the power wheelchair, R19 stated that it was her chair and she had had it for over 5 years. R19 reported that the powerpack stopped working in her power wheelchair sometime in the fall. R19 stated that she had notified the social worker via telephone message months ago, however, no one had followed up with her about repairing her power wheelchair. R19 states that she hopes to have it repaired soon so that she can take herself outside with family when the weather is nice. Review of a Physical Medicine and Rehabilitation Note dated 1/24/24 revealed today patient reveals that she needs a new powerpack for her power wheelchair, discussed with rehab director today. Review of a Physical Medicine and Rehabilitation Note dated 2/7/24 revealed per discussion with rehabilitation director and SW (social work), they are working on obtaining a new battery for her power wheelchair. In an interview on 04/25/24 at 11:05 AM, Therapy Director (TD) H stated that she had just started the position in March, so she was unaware of R19's current need for a new battery for her power wheelchair. TD H denied ever being informed of the need from the previous Therapy Director. In an interview on 04/25/24 at 11:46 AM, Social Worker (SW) M stated that she had recently been informed of the need for a possible repair/new battery for R19's wheelchair. SW M stated that she had recently had a conversation with R19's daughter about the need and was not informed by the previous Therapy Director. SW M stated that she is in communication now with the power wheelchair manufacturer. In an interview on 4/25/24 at 12:19 PM, Director of Nursing (DON) B stated that she had just learned about the issue with R19's powerchair after social work followed up with her. DON B acknowledged that there was a delay in the timeliness of the repair and stated that the expectation would have been for the previous therapy director to inform staff of the needed repairs.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview, and record review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 2 (Resident #s 5 and #22) of 14 reviewed for MDS assessments, resulting in the potential for inaccurate care plans and unmet care needs. Resident 5 (R5) Review of the clinical record, including the Minimum Data Set, dated dated dated [DATE] reflected R5 was a [AGE] year old female admitted to the facility on [DATE]. MDS section B question 0200 of the MDS reflected R5 had adequate hearing - no difficulty in normal conversation, social interaction, listening to TV. (with or without use of hearing aid or hearing appliances if normally used) and did not use a hearing aid. Section B 0300 Hearing aid or other hearing appliance used was coded as No. On 4/23/24 at approximately 11:00 am R5 was observed resting in bed, R5 initially did not respond to any questions, then stated I cant hear you. Multiple methods attempts were made to interview R5/getting closer, deeper tone etc however R5 was not able to engage in conversation. On 4/23/24 at 12:15 pm, family member Y was contacted and interviewed. Family member Y reported R5 has and has had hearing aids for several years. Family member Y stated R5 has profound hearing loss and was not able to communicate without them. Family member Y stated just last week R 5 received a new hearing aids as the former pair needed to be updated. Family member Y stated R5 was having some difficulty putting the new pair in (puts them in upside down) and may need some help until she get more familiar with the new air. 04/25/24 09:31 AM Interview with Social Worker M reported she was not aware that R5 had and routinely wore hearing aids. When queried if she was aware that R5 had hearing loss, SW M stated she was not aware. Resident #22 (R22) According to the clinical record including the quarterly Minimum Data Set (MDS) dated [DATE] reflected Resident #22 (R22) was a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included borderline personality disorder and bipolar disorder. Review of R22's significant change MDS dated [DATE] question A1500 Is the resident currently considered by the state level II Pre-Admission Screening and Annual Resident Review (PASARR) process to have serious mental illness and/or intellectual disability or a related condition? was coded No. Further review of the clinical record reflected two annual Level II Omnibus Budget Reconciliation Act (OBRA) assessments dated 6/11/22 and 7/11/23 that determined R22 had a severe mental illness. On 04/25/24 at 09:49 AM, during an interview with Social Worker M she reported R22 was determined to have a serious mental illness by OBRA and acknowledged question A1500 on MDS dated [DATE] was coded incorrectly.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for 1 (Resident #42) of 14 reviewed, resulting in the potential for unmet care needs and continued falls. Findings include: Review of the Face Sheet revealed Resident #42 (R42) was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included multiple fractures of ribs, muscle weakness, orthostatic hypotension (drop in blood pressure upon standing), hemiplegia and hemiparalysis following cerebral infarction affecting non dominant left side (weakness and/or total loss of function on left side of body after experiencing a stroke), bilateral chronic angle closure glaucoma (bulging of the iris resulting in fluid and pressure build up in the eye), and bilateral blepharitis (inflammation of the eyelids). Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/24 revealed R42 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The Care Plan reflected R42 required partial/moderate assistance with (one, helper(s) and walker, supervision with wheelchair) for ambulation and one assist for toileting. On 4/23/24 at 10:42 AM, during an observation of a neighboring resident room, Staff Member (SM) E was observed in the doorway of R42's room to assist in answering her call light. R42 was seated at the end of her bed with her bedside table in front of her. SM E asked R42 if she needed to use the bathroom. R42 responded with bathroom and then proceeded to continue speaking in another language. SM E stated to R42 please speak English. R42 again attempted to communicate with SM E in a different language. SM E stated that she would let someone know that R42 had to use the bathroom. R42's call light was turned off and SM E exited the area. A family interview was conducted in the room across the hallway from R42. The observation of R42 remained ongoing. In an observation and interview on 4/23/24 at 11:22 AM, R42 was seated in the same position but had her head down resting on the bedside table. As I entered the room, R42 reached up toward me and stated bathroom, bathroom. When queried if she still needed to use the bathroom, R42 pointed toward the bathroom and spoke in a different language. I motioned to her call light and R42 reactivated her call light. An observation around the room revealed no communication tools to utilize to assist with communicating. During the interview attempt, R42 spoke two words in English, bathroom and Romania. Translation services were used to conduct a brief interview and revealed that R42 spoke Romanian and had a concern with getting timely assistance to use the bathroom. R42 reported that she had sustained a fall. In an observation and interview on 4/23/24 at 11:31 AM, Licensed Practical Nurse (LPN) O entered the room to answer R42's call light. When queried how LPN O communicates with R42, LPN O stated that R42 used to speak more English, however, can communicate basic needs like bathroom. LPN O stated that translation services via phone are used for more complex conversations. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan revealed R42 had a communication barrier related to Russian speaking as evidenced by language barrier. Interventions included ensure availability, functioning and effectiveness of adaptive communication equipment: message board, hearing aids, telephone amplifier, computer, pocket talker, ect and provider translator as necessary to communicate with resident . which included instructions on how to access the global translator service via telephone. Review of the same Care Plan revealed R42 had a Falls Care Plan initiated on 5/12/24 with interventions that included educating resident/family about safety reminders and what to do if a fall occurs, encourage resident to wear non-skid footwear when out of bed. Assist resident as needed. Put the call light in reach and encourage her to use it for assistance when needed. Review of a Nurses Note dated 5/14/2023 at 7:16 PM revealed Resident family speaking with writer and oncoming nurse r/t (related to) safety concerns with fall, lack of care night hours, and use of call light .No mention of a fall before this was identified in the progress note. Review of an Incident report dated 5/12/23 at 7:45 AM revealed R42 was discovered on the floor of her room by her bedside commode. R42 stated she had put her call light on, but couldn't wait and needed to use the commode, then slipped and fell to the floor. The post fall evaluation indicated that R42 was barefoot at the time. The immediate intervention was to encourage R42 to wear nonskid socks and wait for assistance. Review of a Nurses Note dated 5/16/2023 11:15 PM revealed Resident lowered to the floor by nurse to prevent fall. Resident was observed with butt half way off commode trying to assist self back to bed. Resident did not wait for assistance. Resident assisted back to bed by nurse and CNA (certified nursing assistant). Educated importance ofuse [sic] of call light. Bedside table/Call light within reach. Review of an Incident Report dated 6/15/23 at 8:02 PM revealed that R42 was discovered on the floor of her room next to her bed. The incident report revealed that R42 was unable to give a description of how the fall occurred. The post fall evaluation revealed that R42 was ambulating without assistance and staff believed the fall was due to environmental factors from R42's room being cluttered. An intervention was added to the Care Plan on 6/15/24 to ensure the room was free from clutter. The Incident Report or post fall evaluation did not describe how the cluttered environment caused the fall to occur. Review of a Nurses Note dated 6/16/2023 6:52 PM revealed Post fall resident [R42] denies acute distress. Alert and orient x4. English barrier. Education provided on safety precautions. Encouraged to use call light for assistance with all transfers. Review of a Nurses Note dated 6/17/2023 6:13 PM revealed Resident [R42] is in room resting [NAME] [sic] call light when needing assistance. Review of a Nurses Note dated 7/9/2023 at 9:00 AM reflected Resident observed by staff, sitting on her floor next to her bed and near her bedside commode. Resident was sitting on her buttocks with legs extended to the front . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Incident Report dated 7/9/23 at 3:28 PM revealed staff responded to R42's room and observed R42 sitting on the floor in her room. Staff assisted R42 off the floor and R42 requested to go to the bathroom. The report indicated that R42 was unable to give a description of the fall. Review of the post fall evaluation reflected staff documentation stating that R42 could not describe what she was doing prior to the fall due to a language barrier and R42 was wet and continent at the time of the fall. The intervention for this fall included removing the bedside commode from R42's room to prevent self-ambulation to the bathroom. This was added to the Care Plan on 7/10/23. Review of a Nurses Note dated 8/1/2023 at 11:29 AM revealed writer went to go answer call light and upon arrival pt (patient) was on the floor next to her bed and in front of her nightstand, pt was assist for injury and decreased cognition, the resident was trying to get back into bed after going to the bathroom unassisted. Review of an Incident Report dated 8/1/23 at 7:55 AM revealed that when answering her call light, R42 was discovered on the floor. R42 reported that she was attempting to self-transfer to bed after using the bathroom. Review of the post fall evaluation revealed one of the initial interventions taken to prevent further falls included removing the bedside commode from R42's room. Removing the bedside commode was previously identified as an intervention on 7/9/23. Review of a Nurses Note dated 8/24/2023 6:26 PM revealed R42 was found on the floor of her room. Review of an Incident Report dated 8/24/23 at 7:28 PM revealed that R42 was discovered on the floor of her room and stated that she was trying to take herself to the bathroom. The post fall evaluation indicated that R42 was wearing slippers with no grip at the time of the fall. The initial intervention was to offer toileting every two hours. 2-hour toileting was initiated on the Care Plan on 8/25/23. Review of a Nurses Note dated 8/25/2023 12:01 PM revealed . Writer spoke to resident using global interpreter services to educate resident on using the call light and waiting for assistance for toileting, resident was able to provide return demonstration of call light, will continue to monitor. Review of a Nurses Note dated 2/9/2024 at 11:10 AM revealed Resident observed on floor in front of wheelchair,resident [sic] states she was trying to self tranfer [sic] to bathroom from the bed to the wheelchair and she fell . Review of an Incident Report dated 2/9/24 at 10:47 AM revealed R42 was discovered on the floor in her room in front of her wheelchair. R42 stated that she was attempting to take herself to the bathroom. Review of the post fall evaluation revealed the intervention for R42's fall was to offer toileting every two hours; however, this was already a previously initiated intervention. In an observation on 04/24/24 at 1:22 PM, R42 was in her recliner and appeared to be sleeping. R42's call light was on her bed, out of reach. In an observation on 04/24/24 at 3:20 PM, R42 was in her recliner and appeared to be sleeping. R42's call light was on her bed, out of reach. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 04/24/24 at 3:27 PM, R42 was observed in her recliner and was awake. R42 sat herself up in her recliner and stated bathroom. When asked if R42 could press her call light for assistance, R42 looked over at the light and attempted to reach the cord to pull the light toward her but was unsuccessful. I assisted with providing R42 with her call light, which, she activated immediately. In an observation and interview on 04/24/24 at 3:31 PM, Registered Nurse (RN) FF entered the room to assist R42 to the bathroom. When asked where the communication board for R42 was, RN FF stated that she was unsure. When asked if the black landline telephone could be used to contact the global translator services, RN FF stated that she was unsure. In an interview on 4/24/24 at 4:00 PM, RN FF stated that she located R42's communication board in the bottom drawer of her dresser and placed it on the windowsill of R42's room. In an observation on 04/25/24 at 9:15 AM, R42 was observed in bed and appeared to be sleeping. An observation was made of the communication board that was in R42's dresser. The communication board had images of commonly requested items/feeling with the corresponding words underneath of the imagine written in English. In an interview on 04/25/24 at 10:33 AM, Certified Nursing Assistant (CNA) G stated that she was familiar with R42. CNA G reported that R42 can use her call light appropriately and that she can state a few words in English, but anything more than the basic needs would require use of the translation services. In an interview on 04/25/24 at 11:44 AM, Social Worker (SW) M stated that translation services are in place for R42 and can be accessed from any phone that has the capability to put the phone on speaker. SW M stated that the instructions for utilizing the translation services can be in R42's electronic medical record. In an interview on 4/25/24 at 12:19 PM, Director of Nursing B reported that the process for falls included filling out an incident report, post fall evaluation, and implementing an intervention to protect the resident from any further falls. The Interdisciplinary Team would review the fall in their meetings and discuss the need for additional intervention. When asked about R42's falls, DON B reported that she is familiar with R42's falls. When asked about the language barrier for investigating the cause of the fall, DON B stated that staff should be utilizing the translation services to inquire with R42 about the fall to try and determine a root cause for the falls. DON B agreed that R42's falls mostly occurred from attempting to use the bathroom which is why offering toileting every two hours is a triggered task for R42, however, the investigation revealed that R42 sustained a fall even when offering toileting was a current intervention and observations of not offering toileting every two hours were made.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review the facility failed to ensure communication services were available and appropriately utilized by staff for one (Resident #42) of two residents reviewed for communication. Findings include: Review of the Face Sheet revealed Resident #42 (R42) was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included multiple fractures of ribs, muscle weakness, orthostatic hypotension (drop in blood pressure upon standing), hemiplegia and hemiparalysis following cerebral infarction affecting non dominant left side (weakness and/or total loss of function on left side of body after experiencing a stroke), bilateral chronic angle closure glaucoma (bulging of the iris resulting in fluid and pressure build up in the eye), and bilateral blepharitis (inflammation of the eyelids). Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/24 revealed R42 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The Care Plan reflected R42 required partial/moderate assistance with (one, helper(s) and walker, supervision with wheelchair) for ambulation and one assist for toileting. On 4/23/24 at 10:42 AM, during an observation of a neighboring resident room, Staff Member (SM) E was observed in the doorway of R42's room to assist in answering her call light. R42 was seated at the end of her bed with her bedside table in front of her. SM E asked R42 if she needed to use the bathroom. R42 responded with bathroom and then proceeded to continue speaking in another language. SM E stated to R42 please speak English. R42 again attempted to communicate with SM E in a different language. SM E stated that she would let someone know that R42 had to use the bathroom. R42's call light was turned off and SM E exited the area. A family interview was conducted in the room across the hallway from R42. The observation of R42 remained ongoing. In an observation and interview on 4/23/24 at 11:22 AM, R42 was seated in the same position but had her head down resting on the bedside table. As I entered the room, R42 reached up toward me and stated bathroom, bathroom. When queried if she still needed to use the bathroom, R42 pointed toward the bathroom and spoke in a different language. I motioned to her call light and R42 reactivated her call light. An observation around the room revealed no communication tools to utilize to assist with communicating. During the interview attempt, R42 spoke two words in English, bathroom and Romania. Translation services were used to conduct a brief interview and revealed that R42 spoke Romanian and had a concern with getting timely assistance to use the bathroom. R42 reported that she had sustained a fall. In an observation and interview on 4/23/24 at 11:31 AM, Licensed Practical Nurse (LPN) O entered the room to answer R42's call light. When queried how LPN O communicates with R42, LPN O stated that R42 used to speak more English, however, can communicate basic needs like bathroom. LPN O stated that translation services via phone are used for more complex conversations. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan revealed R42 had a communication barrier related to Russian speaking as evidenced by language barrier. Interventions included ensure availability, functioning and effectiveness of adaptive communication equipment: message board, hearing aids, telephone amplifier, computer, pocket talker, ect and provider translator as necessary to communicate with resident . which included instructions on how to access the global translator service via telephone. Review of the same Care Plan revealed R42 had a Falls Care Plan initiated on 5/12/24 with interventions that included educating resident/family about safety reminders and what to do if a fall occurs, encourage resident to wear non-skid footwear when out of bed. Assist resident as needed. Put the call light in reach and encourage her to use it for assistance when needed. Review of an Incident Report dated 6/15/23 at 8:02 PM revealed that R42 was discovered on the floor of her room next to her bed. The incident report revealed that R42 was unable to give a description of how the fall occurred. Review of a Nurses Note dated 6/16/2023 6:52 PM revealed Post fall resident [R42] denies acute distress. Alert and orient x4. English barrier. Education provided on safety precautions. Encouraged to use call light for assistance with all transfers. Review of an Incident Report dated 7/9/23 at 3:28 PM revealed staff responded to R42's room and observed R42 sitting on the floor in her room. Staff assisted R42 off the floor and R42 requested to go to the bathroom. The report indicated that R42 was unable to give a description of the fall. Review of the post fall evaluation reflected staff documentation stating that R42 could not describe what she was doing prior to the fall due to a language barrier and R42 was wet and continent at the time of the fall. In an observation and interview on 04/24/24 at 3:31 PM, Registered Nurse (RN) FF entered the room to assist R42 to the bathroom. When asked where the communication board for R42 was, RN FF stated that she was unsure. When asked if the black landline telephone could be used to contact the global translator services, RN FF stated that she was unsure. In an interview on 4/24/24 at 4:00 PM, RN FF stated that she located R42's communication board in the bottom drawer of her dresser and placed it on the windowsill of R42's room. In an observation on 04/25/24 at 9:15 AM, R42 was observed in bed and appeared to be sleeping. An observation was made of the communication board that was in R42's dresser. The communication board had images of commonly requested items/feeling with the corresponding words underneath of the imagine written in English. In an interview on 04/25/24 at 10:33 AM, Certified Nursing Assistant (CNA) G stated that she was familiar with R42. CNA G reported that R42 can use her call light appropriately and that she can state a few words in English, but anything more than the basic needs would require use of the translation services. CNA GG denied using the translation services. In an interview on 04/25/24 at 11:44 AM, Social Worker (SW) M stated that translation services are in place for R42 and can be accessed from any phone that has the capability to put the phone on speaker. SW M stated that the instructions for utilizing the translation services can be in R42's electronic medical record. (continued on next page)

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	235658	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Bluffs Park	355 Huron View Blvd Ann Arbor, MI 48103

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/25/24 at 12:19 PM, Director of Nursing B reported that the process for falls included filling out an incident report, post fall evaluation, and implementing an intervention to protect the resident from any further falls. The Interdisciplinary Team would review the fall in their meetings and discuss the need for additional intervention. When asked about R42's falls, DON B reported that she is familiar with R42's falls. When asked about the language barrier for investigating the cause of the fall, DON B stated that staff should be utilizing the translation services to inquire with R42 about the fall to try and determine a root cause for the falls.

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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. 45038 Based on observation, interview, and record review the facility failed to ensure appropriate treatment and services for contracture management for one resident (#3) of one resident reviewed. Findings Included: Resident #3 (R3) Review of the medical record demonstrated R3 was admitted to the facility 02/22/2013 with diagnoses that included chronic kidney disease, morbid obesity, macular degeneration, insomnia, bradycardia, depression, hyperlipidemia (high fat content in blood), anxiety, dementia, amputation of the left leg above the knee, acquired club foot,(deformity of the foot when compromised nerve connections o irregular blood vessels in the lower extremity due to injury or illness), peripheral vascular disease (PVD), pain in right leg, atherosclerotic heart disease (buildup of plaque in vessels) , colostomy, hypertension, gastroesophageal reflux, atrial fibrillation, congestive heart failure (CHF), and chronic ischemic heart disease (damage or disease in the heart's major blood vessels). Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2024, revealed R3 had a Brief Interview for Mental Status (BIMS) of 12 (moderately impaired cognition) out of 15. During observation and interview on 04/25/2024 at 08:58 a.m. was observed lying down in bed. She explained that she was unable to move her right foot or toes. R3 explained that she wished that the staff would move her right foot and toes on a regular basis, as in the past. She explained that she was unable to wear a shoe on the right foot. R3 denied that the staff performed Range of Motion (ROM) while they were placing her sock on her right foot and denied that staff performed ROM at any other time. Licensed Practical Nurse (LPN) I removed the bed linens that were covering R3's lower extremities. As R3 was lying flat in bed, her right foot was observed to be in planter flexion and her toes were curled toward the bottom of her foot. R3 could not move her foot and only minimally could move her toes. She explained that she was unable to move her foot and toes back toward her head. Review of R3's medical record demonstrated a physician order, written 01/27/2024, which stated Physical Therapy evaluation completed, and treatment initiated. Review of Physical Therapy Treatment Encounter Note, dated 02/21/2024, demonstrated, RNP (Restorative Nursing Program): To facilitate patient maintaining current level of performance and in order to prevent decline, development of an instructions in the following RNPs has been completed with IDT(interdisciplinary Team) : bed mobility and ROM (Active). Review of R3's Point of Care Response (POC) History, demonstrated the task Daily maintenance AAROM (assisted active range of motion) to BL (bilateral) UE (Upper extremities)/LE (Lower extremities) to all major joints incorporated into ADLs (activity of Daily Living) as tolerated. Review of the response for the last 30 days did not demonstrate any documentation of completion or that R3 had refused to have the task performed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's Point of Care Response (POC) history, demonstrated a task: ADL (activities of daily living) care statement, keep right float pillows at all times, report excoriation to peri-stoma for additional assistance. AROM (active range of motion) as tolerated incorporated into ADL's, AAROM (assisted active range of motion) to BL (bilateral) UE(upper extremities/LE (lower extremities) to all major joints incorporated into ADLs as tolerated Review of the response for the last 30 days was documented as yes. In an interview on 04/24/2024 at 01:30 p.m. Certified Nursing Aide (CNA) F explained that she had worked at the facility for 6 years and was currently a full-time employee. She explained that she frequently cares for R3. She explained that R3 has refused to perform range of motion in the past, so she currently does not offer R3 any range of motion while providing her routine daily care. In an interview on 04/25/2024 at 10:46 a.m. Director of Nursing (DON) B explained that facility incorporates ROM (range of motion) with residents into the daily care task. She explained that all Certified Nursing Aides are expected to perform ROM if the POC (Point of Care) documentation instructs that is necessary. DON B was asked how the staff was to document refusal of any ROM since the ADL (activities of daily living) documentation included several different items to be completed? DON B could not explain. DON B was asked to review R3's POC documentation and confirmed that R3 had two different POC task for need of ROM. DON B could not explain why no documentation was present for the POC task Daily maintenance AAROM (assisted active range of motion) to BL (bilateral) UE (Upper extremities)/LE (Lower extremities) to all major joints incorporated into ADLs (activity of Daily Living) as tolerated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review the facility failed to prevent falls for one (Resident #42) of 1 reviewed for falls, resulting in recurrent falls and the potential for serious injury. Findings include: Review of the Face Sheet revealed Resident #42 (R42) was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included multiple fractures of ribs, muscle weakness, orthostatic hypotension (drop in blood pressure upon standing), hemiplegia and hemiparalysis following cerebral infarction affecting non dominant left side (weakness and/or total loss of function on left side of body after experiencing a stroke), bilateral chronic angle closure glaucoma (bulging of the iris resulting in fluid and pressure build up in the eye), and bilateral blepharitis (inflammation of the eyelids). Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/24 revealed R42 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The Care Plan reflected R42 required partial/moderate assistance with (one, helper(s) and walker, supervision with wheelchair) for ambulation and one assist for toileting. On 4/23/24 at 10:42 AM, during an observation of a neighboring resident room, Staff Member (SM) E was observed in the doorway of R42's room to assist in answering her call light. R42 was seated at the end of her bed with her bedside table in front of her. SM E asked R42 if she needed to use the bathroom. R42 responded with bathroom and then proceeded to continue speaking in another language. SM E stated to R42 please speak English. R42 again attempted to communicate with SM E in a different language. SM E stated that she would let someone know that R42 had to use the bathroom. R42's call light was turned off and SM E exited the area. A family interview was conducted in the room across the hallway from R42. The observation of R42 remained ongoing. In an observation and interview on 4/23/24 at 11:22 AM, R42 was seated in the same position but had her head down resting on the bedside table. As I entered the room, R42 reached up toward me and stated bathroom, bathroom. When queried if she still needed to use the bathroom, R42 pointed toward the bathroom and spoke in a different language. I motioned to her call light and R42 reactivated her call light. An observation around the room revealed no communication tools to utilize to assist with communicating. During the interview attempt, R42 spoke two words in English, bathroom and Romania. Translation services were used to conduct a brief interview and revealed that R42 spoke Romanian and had a concern with getting timely assistance to use the bathroom. R42 reported that she had sustained a fall. In an observation and interview on 4/23/24 at 11:31 AM, Licensed Practical Nurse (LPN) O entered the room to answer R42's call light. When queried how LPN O communicates with R42, LPN O stated that R42 used to speak more English, however, can communicate basic needs like bathroom. LPN O stated that translation services via phone are used for more complex conversations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan revealed R42 had a communication barrier related to Russian speaking as evidenced by language barrier. Interventions included ensure availability, functioning and effectiveness of adaptive communication equipment: message board, hearing aids, telephone amplifier, computer, pocket talker, ect and provider translator as necessary to communicate with resident . which included instructions on how to access the global translator service via telephone. Review of the same Care Plan revealed R42 had a Falls Care Plan initiated on 5/12/24 with interventions that included educating resident/family about safety reminders and what to do if a fall occurs, encourage resident to wear non-skid footwear when out of bed. Assist resident as needed. Put the call light in reach and encourage her to use it for assistance when needed. Review of a Nurses Note dated 5/14/2023 at 7:16 PM revealed Resident family speaking with writer and oncoming nurse r/t (related to) safety concerns with fall, lack of care night hours, and use of call light .No mention of a fall before this was identified in the progress note. Review of an Incident report dated 5/12/23 at 7:45 AM revealed R42 was discovered on the floor of her room by her bedside commode. R42 stated she had put her call light on, but couldn't wait and needed to use the commode, then slipped and fell to the floor. The post fall evaluation indicated that R42 was barefoot at the time. The immediate intervention was to encourage R42 to wear nonskid socks and wait for assistance. Review of a Nurses Note dated 5/16/2023 11:15 PM revealed Resident lowered to the floor by nurse to prevent fall. Resident was observed with butt half way off commode trying to assist self back to bed. Resident did not wait for assistance. Resident assisted back to bed by nurse and CNA (certified nursing assistant). Educated importance ofuse [sic] of call light. Bedside table/Call light within reach. Review of an Incident Report dated 6/15/23 at 8:02 PM revealed that R42 was discovered on the floor of her room next to her bed. The incident report revealed that R42 was unable to give a description of how the fall occurred. The post fall evaluation revealed that R42 was ambulating without assistance and staff believed the fall was due to environmental factors from R42's room being cluttered. An intervention was added to the Care Plan on 6/15/24 to ensure the room was free from clutter. The Incident Report or post fall evaluation did not describe how the cluttered environment caused the fall to occur. Review of a Nurses Note dated 6/16/2023 6:52 PM revealed Post fall resident [R42] denies acute distress. Alert and orient x4. English barrier. Education provided on safety precautions. Encouraged to use call light for assistance with all transfers. Review of a Nurses Note dated 6/17/2023 6:13 PM revealed Resident [R42] is in room resting [NAME] [sic] call light when needing assistance. Review of a Nurses Note dated 7/9/2023 at 9:00 AM reflected Resident observed by staff, sitting on her floor next to her bed and near her bedside commode. Resident was sitting on her buttocks with legs extended to the front . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Incident Report dated 7/9/23 at 3:28 PM revealed staff responded to R42's room and observed R42 sitting on the floor in her room. Staff assisted R42 off the floor and R42 requested to go to the bathroom. The report indicated that R42 was unable to give a description of the fall. Review of the post fall evaluation reflected staff documentation stating that R42 could not describe what she was doing prior to the fall due to a language barrier and R42 was wet and continent at the time of the fall. The intervention for this fall included removing the bedside commode from R42's room to prevent self-ambulation to the bathroom. This was added to the Care Plan on 7/10/23. Review of a Nurses Note dated 8/1/2023 at 11:29 AM revealed writer went to go answer call light and upon arrival pt (patient) was on the floor next to her bed and in front of her nightstand, pt was assist for injury and decreased cognition, the resident was trying to get back into bed after going to the bathroom unassisted. Review of an Incident Report dated 8/1/23 at 7:55 AM revealed that when answering her call light, R42 was discovered on the floor. R42 reported that she was attempting to self-transfer to bed after using the bathroom. Review of the post fall evaluation revealed one of the initial interventions taken to prevent further falls included removing the bedside commode from R42's room. Removing the bedside commode was previously identified as an intervention on 7/9/23. Review of a Nurses Note dated 8/24/2023 6:26 PM revealed R42 was found on the floor of her room. Review of an Incident Report dated 8/24/23 at 7:28 PM revealed that R42 was discovered on the floor of her room and stated that she was trying to take herself to the bathroom. The post fall evaluation indicated that R42 was wearing slippers with no grip at the time of the fall. The initial intervention was to offer toileting every two hours. 2-hour toileting was initiated on the Care Plan on 8/25/23. Review of a Nurses Note dated 8/25/2023 12:01 PM revealed . Writer spoke to resident using global interpreter services to educate resident on using the call light and waiting for assistance for toileting, resident was able to provide return demonstration of call light, will continue to monitor. Review of a Nurses Note dated 2/9/2024 at 11:10 AM revealed Resident observed on floor in front of wheelchair,resident [sic] states she was trying to self transfer [sic] to bathroom from the bed to the wheelchair and she fell . Review of an Incident Report dated 2/9/24 at 10:47 AM revealed R42 was discovered on the floor in her room in front of her wheelchair. R42 stated that she was attempting to take herself to the bathroom. Review of the post fall evaluation revealed the intervention for R42's fall was to offer toileting every two hours; however, this was already a previously initiated intervention. In an observation on 04/24/24 at 1:22 PM, R42 was in her recliner and appeared to be sleeping. R42's call light was on her bed, out of reach. In an observation on 04/24/24 at 3:20 PM, R42 was in her recliner and appeared to be sleeping. R42's call light was on her bed, out of reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 04/24/24 at 3:27 PM, R42 was observed in her recliner and was awake. R42 sat herself up in her recliner and stated bathroom. When asked if R42 could press her call light for assistance, R42 looked over at the light and attempted to reach the cord to pull the light toward her but was unsuccessful. I assisted with providing R42 with her call light, which, she activated immediately. In an observation and interview on 04/24/24 at 3:31 PM, Registered Nurse (RN) FF entered the room to assist R42 to the bathroom. When asked where the communication board for R42 was, RN FF stated that she was unsure. When asked if the black landline telephone could be used to contact the global translator services, RN FF stated that she was unsure. In an interview on 4/24/24 at 4:00 PM, RN FF stated that she located R42's communication board in the bottom drawer of her dresser and placed it on the windowsill of R42's room. In an observation on 04/25/24 at 9:15 AM, R42 was observed in bed and appeared to be sleeping. An observation was made of the communication board that was in R42's dresser. The communication board had images of commonly requested items/feeling with the corresponding words underneath of the imagine written in English. In an interview on 04/25/24 at 10:33 AM, Certified Nursing Assistant (CNA) G stated that she was familiar with R42. CNA G reported that R42 can use her call light appropriately and that she can state a few words in English, but anything more than the basic needs would require use of the translation services. In an interview on 04/25/24 at 11:44 AM, Social Worker (SW) M stated that translation services are in place for R42 and can be accessed from any phone that has the capability to put the phone on speaker. SW M stated that the instructions for utilizing the translation services can be in R42's electronic medical record. In an interview on 4/25/24 at 12:19 PM, Director of Nursing B reported that the process for falls included filling out an incident report, post fall evaluation, and implementing an intervention to protect the resident from any further falls. The Interdisciplinary Team would review the fall in their meetings and discuss the need for additional intervention. When asked about R42's falls, DON B reported that she is familiar with R42's falls. When asked about the language barrier for investigating the cause of the fall, DON B stated that staff should be utilizing the translation services to inquire with R42 about the fall to try and determine a root cause for the falls. DON B agreed that R42's falls mostly occurred from attempting to use the bathroom which is why offering toileting every two hours is a triggered task for R42, however, the investigation revealed that R42 sustained a fall even when offering toileting was a current intervention and observations of not offering toileting every two hours were made.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview, and record review the facility failed to ensure pain medications were given as ordered for two (resident #45 and #269) of three reviewed, resulting in increased pain and the potential for unmanaged pain. Findings include: Resident #45(R45) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R45 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included breast cancer, bone cancer, secondary cancer of liver and bile duct, chronic pain, stage 3 pressure wound(full thickness tissue loss), hip fracture and malnutrition. The MDS reflected R45 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact. Continued review of the MDS reflected R45 described pain as severe, almost constant pain and received both scheduled and as needed pain medications During an observation on 4/23/24 at 10:05 AM, CNA staff entered R45 room and answered call light. R45 was overheard reporting need for pain medications. CNA staff informed R45 nursing staff was on the way down the hall passing medications and would be to R45 room soon and turned off the call light. During an observation and interview on 4/23/24 at 10:32 AM, R45 was noted to be lying in bed with facial grimacing with minimal adjustments in position. R45 reported pain medications are frequently late including today and reported feeling ill related to elevated pain level. R45 reported when she reports to staff frequently told, five residents ahead of you, when nurse is passing medications. This surveyor exited R45 room and observed two nurses outside R45 door prepping medications. Review of R45's Medication Administration Record(MAR), dated 4/1/24 through 4/25/24, reflected, Morphine Sulfate ER Oral Tablet Extended Release 15 MG (Morphine Sulfate) Give 1 tablet by mouth every 12 hours for pain. The pain medication was scheduled twice daily for 9:00 a.m. and 9:00 p.m.(Observed administered to R45 on 4/23/24 after 10:35 a.m.) Review of the facility, Controlled Substances Proof of Use document, dated 4/17/24 to 4/25/24, reflected R45 was administered Morphine SulfateER on e tablet on 4/23/24 at 10:34 a.m.(Physician order was for 9:00am). Continued review of the Electronic Medical Record with no evidence Physician had been notified. Continued review of Controlled Substance Proof of Use record reflected two addition occasions of Physician ordered Morphine Sulfate ER administered greater than one hour after scheduled time including up to two hours and 15 minutes after schedule dose on 4/19/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/24 at 12:49 PM, Director of Nursing(DON) B reported would expect staff to follow Physician orders including administration of narcotic pain medications. DON B reported would expect nursing staff to administer medications within one hour prior or one hour after scheduled time and document on the Medication Administration Record immediately after medications administered as well as Controlled Substance Record Proof of Use record if applicable. DON B reported unable to provide Medication Audit Report for residents according to corporate policy to verify medication administration times. Resident #269(R269) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R269 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included disc degeneration, Osteoarthritis, spinal stenosis, and after care post hip replacement. The MDS reflected R269 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact. Continued review of the MDS reflected R269 described pain as, very severe, horrible, frequent pain and received both scheduled and as needed pain medications. During an observation and interview on 4/23/24 at 12:08 PM, R269 was observed in bed, and reported was recently admitted to the facility after right hip replacement surgery on 4/15/24. R269 reported was scheduled to have Fentanyl 75mg patched changed on 4/19/24 but was told was not available and did not receive until 4/21/24. R269 reported had order for Gabapentin for pain as well that did not receive as ordered. R269 reported had been on Fentanyl 75mg for pain prior to admission and started to go through terrible withdraw symptoms and uncontrolled pain of 8 out of 10 on pain scale and uncontrolled shaking in legs which caused increased pain in recent new hip joint. Review of R269 Hospital Discharge Summary, dated 4/16/24, reflected, fentaNYL 75 mcg/hr Commonly known as: DURAGESIC Start taking on: April 19, 2024 Place 1 patch on the skin every 3rd(third) day .gabapentin 300 mg capsule .Take 1 capsule(300 mg total)by mouth 3(three) times a day for 3 days. Review of the MAR, dated 4/16/24 through 4/23/24, reflected R269 had a physician order for, Gabapentin Oral Capsule 300 MG .Give 1 capsule by mouth every 8 hours for pain .fentaNYL Transdermal Patch 72 Hour 75 MCG/HR .Apply 1 patch transdermally every 72 for pain and remove per schedule-Start Date-4/16/2024 2200 . The MAR reflected R269 missed two doses of Gabapentin on 4/19/24 and 4/20/24 and did not receive physician ordered Fentanyl on 4/19/24. Continued review of the MAR reflected did not receive Fentanyl patch until 4/21/24(2 days after scheduled dose). During an interview on 4/24/24 at 2:40 PM, Registered Nurse (RN) U reported facility had both Fentanyl 25mcg and 12mcg available in pharmacy backup as well as Gabapentin 100 and 300mg on both 1st and 2nd floor of the facility. RN U reported medications, including narcotics, can be drop shipped from pharmacy within 6 hours at the latest. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/24 at 3:14 PM, RN Unit Manager (RN) FF reported new admission process for residents with narcotic medications included request for paper scripts from hospital. RN FF reported would expect have medications to be drop shipped to the facility from the pharmacy no longer than three hours. RN U reported R269 should have received Fentanyl Patch 4/19/24 and should not have been 4/21/24. RN FF reported R269 EMR should have reflected documentation to reflect reason for delay. During an interview 4/25/24 at 10:01 AM, RN FF reported after review was unsure why script was not written and sent on admission on 4/16/24. RN FF reported after knowledge of missing medication on 4/19/24 would expect script to be available the next day(4/20/24). RN FF reported Physician gave permission to keep prior patch on R269 until available and verified EMR reflected no evidence of communication. RN FF reported would expect staff to document in EMR. RN RR verified Gabapentin and Fentanyl are available in pharmacy back up in facility. During an interview on 4/25/24 at 12:43 PM, DON B reported would expect nursing staff to obtain written script for Controlled medications on admission. DON B reported would expect facility to order medications and pharmacy drop ship medications within no longer than six hours. DON B reported would expect nursing staff to contact physician and document in the medical record and verified Fentanyl and Gabapentin were available in pharmacy back up located in the facility.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review the facility failed to provide sufficient staff to meet residents' needs, as voiced by 6 resident and family interviews (Resident #19, 41, 42, 50, 167, and 323), from a total sample of 14 residents, resulting in unmet needs. Resident #19 Review of the Face Sheet revealed Resident #19 (R19) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included difficulty in walking, shortness of breath, repeated falls, and paralytic gait. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/3/24 revealed R19 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). In an observation and interview on 04/23/24 at 2:59 PM, R19 was in her room watching television. R19 reported that she felt staffing was an issue. When asked to explain, R19 stated that at home, her normal routine was to wake up at 6:00 AM, rest in the recliner until 9:00 AM when her home health aide arrived to assist her with getting around for the day. R19 reported that she would like to be up by 10:00 AM everyday. Now, despite communicating her preference of when she would like to get up with staff, she has to wait until 11:00 AM, and sometimes up to 12:00 PM to get out of bed. R19 stated that staff will answer her light and tell her that she is on the list, but, they cannot get to her until at least 11:00 AM to assist with getting her out of bed for the day. In on observation and interview on 04/24/24 at 1:27 PM, R19 was observed in her wheelchair watching television. R19 appeared to be a bit distressed. When queried if she was okay, R19 looked up at her clock and said that she had to go to the bathroom. When asked if she had informed a certified nursing assistant (CNA), R19 stated that a staff member had answered her call light around 1:00 PM. R19 asked for assistance into the bathroom and was told that the CNA would be back because she had to feed someone. In conversation, R19 stated I hope she comes soon, I really have to go to the bathroom. In an observation on 04/24/24 01:40 PM, a CNA entered R19's room and said ok [R19], I'm ready now. Resident #41 Review of the Face Sheet revealed Resident #21 (R21) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included weakness and dysphagia. In an observation and interview on 4/23/24 at 12:37 PM, R21 was in her room, visiting with a family member. Family Member (FM) W stated that he visits often. R21 and FM W both expressed concerns with short staffing and longer call light response time on the weekends. Resident #42 Review of the Face Sheet revealed Resident #42 (R42) was admitted to the facility on [DATE] (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and readmitted to the facility on [DATE] with diagnoses that included multiple fractures of ribs, muscle weakness, orthostatic hypotension (drop in blood pressure upon standing), hemiplegia and hemiparalysis following cerebral infarction affecting non dominant left side (weakness and/or total loss of function on left side of body after experiencing a stroke), bilateral chronic angle closure glaucoma (bulging of the iris resulting in fluid and pressure build up in the eye), and bilateral blepharitis (inflammation of the eyelids). Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/24 revealed R42 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The Care Plan reflected R42 required partial/moderate assistance with (one, helper(s) and walker, supervision with wheelchair) for ambulation and one assist for toileting. On 4/23/24 at 10:42 AM, during an observation of a neighboring resident room, Staff Member (SM) E was observed in the doorway of R42's room to assist in answering her call light. R42 was seated at the end of her bed with her bedside table in front of her. SM E asked R42 if she needed to use the bathroom. R42 responded with bathroom and then proceeded to continue speaking in another language. SM E stated to R42 please speak English. R42 again attempted to communicate with SM E in a different language. SM E stated that she would let someone know that R42 had to use the bathroom. R42's call light was turned off and SM E exited the area. A family interview was conducted in the room across the hallway from R42. The observation of R42 remained ongoing. In an observation and interview on 4/23/24 at 11:22 AM, R42 was seated in the same position but had her head down resting on the bedside table. As I entered the room, R42 reached up toward me and stated bathroom, bathroom. R42's call light was reactivated at this time. In an observation and interview on 4/23/24 at 11:31 AM, Licensed Practical Nurse (LPN) O entered the room to answer R42's call light. Resident #50 In an observation and interview on 04/23/24 at 3:21 PM, R50 was observed in his bed watching television. R50 was easily conversant, understood questions and answered appropriately. R50 reported having concerns with call light response time. R50 stated that he has to wait up to an hour for his call light to be answered and at times, his call light is not in reach. R50 reported more recently on 4/22/24 after dinner, he did not have his call light and required staff assistance. He stated the only was to notify staff was to yell out for help. R50 reported hearing a group of staff in the hall talking so he yelled out can someone come help me? R50 stated that after yelling out a few times, one of the staff members in the hallway replied no and he could hear them laughing afterward. In an observation on 4/24/23 at 2:57 PM, R50's call light was observed on. Human Resources (HR) D answered the light and assisted with finding help for R50. In an observation and interview on 04/24/24 at 3:13 PM, when asked if R50 had ever seen HR D before, he stated I have never seen her answer my call light in my life and stated that it was surprising. Resident #323 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medical Record revealed Resident #323 (R323) admitted to the facility on [DATE] with diagnosis which included a fall and muscle weakness. A quick review of R323's Care Plan prior to entry into the room revealed R323's primary language was Mandarin. In an observation and interview on 4/23/24 at 12:14 PM, R323 greeted me with a smile and waved me into her room. R323 quickly obtained her tablet which translated during real time. R323 stated that call light response was a concern and stated, I think this needs to be improved, I am worried that I will receive no help if something urgent happens. R323 stated that she typically has to approach the nurse's station in an attempt to get the attention of the staff. R323 asked if I wanted to test the call light and activated her light. On 4/23/24 at 12:16, Human Resources (HR) D knocked, asked permission before entering the room, and asked R323 if she needed anything because her call light was on. R323 blankly stared back because she speaks Mandarin and could not understand the question. HR D again asked if R323 needed anything, however, R323 cannot understand without the use of the translator. I reported that we did not need anything at the moment. HR D asked if R323 could shut off her call light by pulling the level back, however, R323 struggled with this instruction because the request was not translated into the tablet device and unable to be understood by R323. After HR D exited the room, R323 spoke in her tablet which translated to I have done this many times, this time was an accident. I have not seen that lady before. 27306 Resident #167 On 04/23/24 at 10:55 AM R#167 family member Z was interviewed and stated the family takes full shifts at the facility Someone must be here 24 -7, due to lack of staff. Family member Z gave the example of just last night between 7:00 pm and 8:00 pm R167's call light was on for over 45 minutes, family member Z reported she was forced to take her loved one to the bathroom because there was no staff to be found and her family member could not wait any longer. On 04/23/24 at 10:40am interview with Certified Nursing Assistant (CNA) P it was reported an assignement of 16 residents today with some residing on a different hallway. When queried if there was a pager or what system was used to be alerted to resident call light being activated, CNA P stated there was no system per say, there was no was to see or hear call lights on the other hallway that was assigned, I just need to leave this hall and go check on the other hall. Review of the most recent Resident Council minutes dated 4/10/24 call light response time was a concern. The facility response to the grievance form dated 4/12/24 reflected they would educate staff on call light response time.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review the facility failed to ensure proper storage of medications for two residents (Resident #7, 42) out of 56 residents, resulting in the potential for unauthorized access to medications, medication errors, and the potential for adverse reactions/side effects. Findings include: Resident #7 Review of the facesheet revealed Resident #7 (R7) admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis which included obstructive sleep apnea and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/22/24 revealed R42 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). In an observation and interview on 04/23/24 at 11:54 PM, R7 was observed in her room and looking out the window. Two inhalers were observed on the bed of R7. R7 reported that they are her inhalers. She has kept them in the top drawer for about a year and uses them as needed. R7 stated that she knows how to use the inhalers and ensures that she writes her name and the date on the inhalers. An observation of the inhalers revealed that they were dated and had the residents name on them with a black sharpie. R7 verified that the inhalers were her Spiriva handihaler and an Breo Ellipta inhaler. On 04/24/24 at 1:51 PM, Licensed Practical Nurse (LPN) R was providing supervision while the medication cart was being inspected. R7's inhalers from the day before were observed in the bottom drawer of the cart. When asked if LPN R knew anything about the inhalers being removed from the room, LPN R reported that she did not know anything about the inhalers. LPN R stated that she took report from LPN Q. In an interview on 4/24/24 at 2:07 PM, R7 reported that someone came into her room this morning and said, state is here so we have to remove your inhalers from your room. R7 was unsure who the staff member was. In a telephone interview on 4/24/24 at 2:33 PM, LPN Q denied knowing who R7 was despite working on that unit hours prior. LPN Q denied being familiar with the name of R7 or the room number of R7. When asked if LPN Q removed inhalers from a resident's room during her last shift, she stated that she did. When asked why, she stated that she cannot remember anything. Review of R7's Physician Order's verified that the two inhalers were active orders. A list containing all residents with approved self-administration of medication assessments was provided. R7's or R14's name was not on the list. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/25/24 at 12:19 PM, Director of Nursing B reported that the process of administering and storing medication in a resident's room was to conduct an assessment to ensure that the resident understands the medication and can competently and safely administer the medication. DON B stated that medications required to be stored in a lockbox. DON B had been informed about the inhalers from LPN R and had started the process of assessing for self-administration but did not know about R42's medications. Resident #42 Review of the Face Sheet revealed Resident #42 (R42) was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included multiple fractures of ribs, muscle weakness, orthostatic hypotension (drop in blood pressure upon standing), hemiplegia and hemiparalysis following cerebral infarction affecting non dominant left side (weakness and/or total loss of function on left side of body after experiencing a stroke), bilateral chronic angle closure glaucoma (bulging of the iris resulting in fluid and pressure build up in the eye), and bilateral blepharitis (inflammation of the eyelids). Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/24 revealed R42 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The Care Plan reflected R42 required partial/moderate assistance with (one, helper(s) and walker, supervision with wheelchair) for ambulation and one assist for toileting. In an observation and interview on 4/23/24 at 11:22 AM, R42 was observed in her room sitting on the side of her bed. Two inahlers and three eye drop bottles were observed on her windowsill. The two inhalers were Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate). One eye drop was labeled as Brimonidine Tartrate Ophthalmic Solution 0.2 %. One eye drop was labeled as Dorzolamide HCl-Timolol Mal Ophthalmic Solution 22.3-6.8 MG/ML (Dorzolamide HCl-Timolol Maleate). The last bottle of eyedrops was labeled as Lantaprost 0.005%. All four medications had R42's name on them. In an interview on 4/23/24 at 11:31 AM, Licensed Practical Nurse (LPN) O entered the room during my observation of the medications. LPN O stated that she thinks R42 has a self-administration assessment for the medications. The same medications were observed in R42's room on 4/24/24 and 4/25/24. Review of R42's Physician Order's verified that the two inhalers were active orders. A list containing all residents with approved self-administration of medication assessments was provided. R7's or R14's name was not on the list. In an interview on 4/25/24 at 12:19 PM, Director of Nursing B reported that the process of administering and storing medication in a resident's room was to conduct an assessment to ensure that the resident understands the medication and can competently and safely administer the medication. DON B stated that medications required to be stored in a lockbox. DON B had been informed about the inhalers from LPN R and had started the process of assessing for self-administration but did not know about R42's medications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to justify the use of an antipsychotic medication for one (Resident #5) of five reviewed. Findings include: Review of the medical record revealed Resident #5 (R5) was admitted to the facility on [DATE] with diagnoses that included, visual hallucinations, adjustment disorder with depressed mood, and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date of 1/5/24 revealed R5 had modified independence with cognitive skills for daily decision making. On 04/24/24 at 2:40 PM, R5 was observed sitting in a wheelchair in her room. R5 was pleasant and carried on a conversation about what she had for lunch that day. Review of the Physician's Order history revealed on 3/30/23 R5 was prescribed 75 mg of Quetiapine (Seroquel-antipsychotic medication) at bedtime for depression with delirium. On 4/11/23, the dose was reduced to 50 mg at bedtime for depression and delirium. On 5/24/23, the dose was further reduced to 25 mg at bedtime for depression with delirium. Review of the Nurse Practitioner Note dated 5/26/23 revealed Seroquel was reduced from 50 [mg(milligrams)] to 25 mg earlier this week. Pt [patient] requested 50 mg back. I called and spoke to pt's dtr [daughter], who reported that pt had previously gone through the GDR [Gradual Dose Reduction] and was unsuccessful. Pt and her dtr feel comfortable staying at 50 mg [at bedtime]. Will change back to 50 mg [at bedtime]. The note did not include any mention of hallucinations. On 5/26/23, R5's Quetiapine was increased back to 50 mg at bedtime for depression with delirium. Review of the Physician's Note dated 6/23/23 revealed In terms of confusion, patient has a history of delusions/hallucinations. She saw a psychiatrist a couple years ago who prescribed nightly Seroquel. The patient experiences sun downing but has never been agitated or caused herself harm. She has intermittently complained of insects crawling near her over the past day. Seroquel seems to help, but as noted confusion has been worse recently. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy Consultation Report dated 7/13/23 revealed [R5 appears to have tolerated a dose reduction of her Quetiapine to 50 mg HS [at bedtime] on 4/11/23. Recommendation: Please consider a further reduction to Quetiapine 25 mg HS. The physician's response was checked off as I decline the recommendation(s) above because GDR is CLINICALLY CONTRAINDICATED for this individual as indicated below (NOTE: Please check option #1 or #2 AND provide patient-specific rationale on the lines below.) Option #2 was checked and revealed The resident's targe symptoms returned or worsened after the most recent GDR attempt [5/22/23 handwritten above GDR attempt] within the facility and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW. Please provide CMS REQUIRED patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual: The handwritten rationale revealed Did not tolerate documentation in PCC [electronic medical record]. The form was signed by the physician on 7/19/23. Review of the Social Services Note dated 7/27/23 revealed Patient's daughter stopped by SW [Social Work] office expressing continued concerns in regards to patient's increasing delirium and hallucinations. Patient's daughter reporting that patient's delusions are increasing in frequency and detail. Patient has been reporting to her daughter that she is set to marry a man named [man's name] and points to the direction of the window insinuating [man's name] is standing at the window. Patient reports to daughter that [man's name] family visited today to approve her marriage and that she has called her other daughter asking for a guest list and another daughter to make wedding favors. Daughter reports on another visit patient asked if she could hear the music and that it was repeating I love you, I love you. Today, daughter came to visit and patient was in her wheelchair talking with head tilted towards the floor. Patient reported she was talking to [man's name] in the floor and was having difficulty hearing him over the speaker. Patient's daughter reports the delusions are not harmful and patient is not distressed or disturbed but family is concerned they are becoming worse. On 7/28/23, R5's dose of Quetiapine was increased to 75 mg at bedtime for depression with delirium. Review of the psychiatric services progress note dated 11/15/23 revealed Adjustment disorder with depressed mood .May consider GDR of Seroquel as patient has remained stable. Would recommend to trial a GDR down to 50 mg [at bedtime] and monitor for failure. A GDR was not attempted. On 11/30/23, R5's Quetiapine order was rewritten with anxiety as an indication for use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy Consultation Report dated 12/1/23 revealed [R5] receives an antipsychotic, Quetiapine, without documentation of diagnosis and adequate indication for use, in the medical record . Please clarify diagnosis on the order as anxiety is not an appropriate diagnosis. Recommendation: If the antipsychotic order is to continue, please update the medical record to include: 1. the specific diagnosis/indication requiring treatment that is based upon an assessment of the resident's condition and therapeutic goals. 2. a list of the symptoms or target behaviors (e.g. hallucinations) including their impact on the resident (e.g., increases distress, presents a danger to the resident or others, interferes with his/her ability to eat) AND 3. documentation that other causes (e.g. environmental) and medications have been considered, that individualized nonpharmacological interventions are in place, and that ongoing monitoring has been ordered. Rationale for Recommendation: CMS requires the resident's medical record include documentation of adequate indications for medication use and the diagnoses condition for which a medication is prescribed. The physician's response was hallucinations, depression. On 12/4/23 the Quetiapine order was rewritten to include the indication for use as hallucinations, depression. The medical record did not reveal documentation of a negative impact of R5's hallucinations, other causes and medications that have been considered, and individualized nonpharmacological interventions that were in place. The psychiatric services progress note dated 2/8/24 revealed Adjustment disorder with depressed mood . May consider GDR of Seroquel as patient has remained stable. Would recommend to trial a GDR down to 50 mg [at bedtime] and monitor for failure. A GDR was not attempted. Review of the Antipsychotic Risk Benefit Medication Evaluation for Seroquel dated 3/14/24 revealed nothing was checked off for Diagnosis (check all that apply): *Hallucinations, Delusions and Paranoia must be documented in the medical record to be frightful in nature. Nothing was checked off for Existing disease states which may be affected or worsened by the addition of antipsychotic therapy or for The benefits of this anti-psychotic medication outweigh the above identified risks due to: In an interview on 04/24/24 at 2:50 PM, Licensed Practical Nurse (LPN) X reported they were familiar with R5 and had worked with R5 for quite a while. LPN X reported R5 did not have a history any behaviors, hallucinations, or delusions. In an interview on 04/25/24 at 8:33 AM, Certified Nursing Assistant (CNA) P reported R5 was very pleasant and did not have any behaviors, delusions, or hallucinations. Review of R5's behavior monitoring documentation revealed hallucinations and delusions were not listed as behaviors that were being tracked or documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235658	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Bluffs Park	355 Huron View Blvd Ann Arbor, MI 48103

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/25/24 at 8:37 AM, Social Worker (SW) K and SW M reported behaviors, hallucinations, and delusions would be charted in the medical record. SW K reported R5's hallucinations and delusions included hearing people talking in the floor and the belief that she is getting married. SW K reported she spoke with R5's daughter who reported the delusions don't scare her; they make her happy. When asked about documentation of R5's hallucinations and delusions, SW M reported the last documentation was in July (the Social Services Progress note reference above) and that the physician's notes in February and March reference them, but they don't say details. SW K reported they spoke with R5's daughter often and no hallucinations or delusions have been reported recently. When asked about other causes and medications that have been considered and individualized nonpharmacological interventions that are in place, SW M reported family visits and because the hallucinations and delusions aren't so fearful to her, R5's daughter will discuss the hallucinations with R5 because they make R5 happy. In an interview on 04/25/24 at 10:50 AM, Director of Nursing (DON) B was asked about the did not tolerate documentation per the pharmacy Consultation Report dated 7/13/23. DON B reported the physician's notes dated 6/23/23 and 10/23/23 reflected In terms of confusion, patient has a history of delusions/hallucinations. She saw a psychiatrist a couple years ago who prescribed nightly Seroquel. The patient experiences sun downing but has never been agitated or caused herself harm. She has intermittently complained of insects crawling near her over the past day. Seroquel seems to help, but as noted confusion has been worse recently. When asked why Quetiapine was increased again after the attempted GDR, DON B reported it was not clear in the notes. When asked why another GDR was not attempted after the psychiatric progress notes from 11/15/23 and 2/8/24, DON B reported it was unclear. When asked about the pharmacy Consultation Report dated 12/1/23 and documentation for the list of symptoms or target behaviors including their impact on the resident and documentation that other causes and medications have been considered, and that individualized nonpharmacological interventions were in place, DON B reported the documentation should be in the progress notes. Documentation was requested at that time, but not provided prior to the survey exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235658	A. Building B. Wing	04/25/2024

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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 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, interview, and record review 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 the facility's total census of 54 residents who receive meal services (2 nothing by mouth residents, or NPO) out of the facility's total census of 56 residents. Findings include: On 4/23/24 at 11:26 AM, at 11:32 AM and at 12:11 PM, Dietary aide, staff DD, was observed not using a hand barrier to shut off the faucet when done washing their hands. On 4/23/24 at 11:54 AM, the surveyor requested the facility's hand hygiene policy from Dietary Manager, staff AA, to review. At this time the surveyor asked staff AA if they had conducted any trainings with staff on the proper procedure to wash their hands to which they stated, Yes, and we have a sign posted at our sinks. On 4/23/24 at 11:37 AM, and at 11:58 AM, Chef, staff CC, was observed not using a hand barrier to shut off the faucet when done washing their hands. On 4/23/24 at 11:43 AM, Registered Dietitian, staff BB, was observed not using a hand barrier to shut off the faucet when done washing their hands. On 4/23/24 at 12:05 PM, record review of the posted policy titled, personal hygiene revealed that the facility has a hand washing procedure in place identifying when it is required to wash hands and how it should be conducted. On 4/25/24 at 9:58 AM, Dietary aide, staff DD, was observed not using a hand barrier to shut off the faucet when done washing their hands. On 4/25/24 at 10:18 AM, Chef, staff CC, was observed not using a hand barrier to shut off the faucet when done washing their hands. Review of the U.S. Public Health Service 2017 Food Code, Chapter 2-301.12 Cleaning Procedure, directs that: (C) TO avoid recontaminating their hands or surrogate prosthetic Devices, FOOD EMPLOYEES may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a HANDWASHING SINK or the handle of a restroom door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235658	A. Building B. Wing	04/25/2024

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32000 Based on observation and interview the facility failed to provide a safe, functional, and sanitary environment for the facilities census of 56 residents and its staff resulting in an increased potential for harm. Findings include: On 4/23/24 between 2:22 PM, and 2:48 PM, during an environmental tour of the facility the following observations were made: An accumulation of dust and debris was observed on the flooring of the [NAME] Hall's dietary storage closet. Two physical therapy cold compresses were observed stored in the activity room's freezer designated for food storage only. Lift batteries and charging stations were observed being stored in the first and second floor's soiled utility rooms. On 4/23/24 at 2:26 PM, the surveyor inquired Housekeeping Supervisor, Staff EE, on if the lift batteries and charging stations would normally be stored in a soiled utility room to which they replied, I think they always have been, but we can move them to a cleaner area.