STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235666	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Grand Blanc	1330 Grand Pointe Court Grand Blanc, MI 48439

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review the facility failed to ensure that residents' rights were being honored for one resident (Resident #21) of 2 sampled residents reviewed for residents' rights, resulting in the facility staff refusing to provide Resident #21 with requested dietary wishes. Findings include: Resident #21(R21): Review of the Face Sheet and Minimum Data Set (MDS), dated [DATE], reflected R21 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included atrial fibrillation(irregular heart rate), recent pneumonia, urinary tract infection within past 30 days, gastroesophageal reflux disease, hypertension(high blood pressure), chronic obstructive pulmonary disease and depression . The MDS reflected R21 had a BIMS (cognitive assessment tool) score of 10 which indicated her ability to make daily decisions was moderately impaired. The MDS reflected eating or oral hygiene were not assessed related to, Not attempted due to medical condition or safety condition. The MDS reflected R21 was dependent on care for bathing, dressing, toileting, and putting on footwear. During an observation and interview on 5/30/24 at 12:26 PM, R21 was sitting up in chair and appeared calm and pleasant and able to answer questions without difficulty. R21 reported facility staff will not allow her to take anything by mouth and has a tube that staff give her feedings through. R21 reported she wants to eat food but they will not let her. R21 appeared sad and had tears in eyes when talking about not eating anything since admission on 4/19/24. R21 reported sister is very involved with her care and helps make medical decisions. R21 reported physician asked R21 today if she wanted comfort food and resident reported she was looking forward to that. During an observation and interview on 5/31/24 at 11:23 AM, R21 was sitting in room and appeared in pleasant mood and able to answer questions without difficulty. R21 reported speech therapy staff gave her 2 tablespoons of ice cream yesterday followed by X-ray. R21 reported passed X-ray and speech therapy planned to return today again around noon with ice cream and was looking forward to visit. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R21's Speech-Language pathologist Video Swallow Study(VFSS), dated 4/11/24, reflected, Pt is a 77 y/o F admitted s/p fall. RN reported pt is receiving IV antibiotics for UTI[urinary tract infection] and R[right] lower lobe PNA[pneumonia]. Pt is familiar to SLP from multiple previous assessments. Pt's sister was present. Pt has undergone multiple VFSS secondary to ongoing h/o dysphasia. Most recent study showed silent aspiration of thin liquids, nectar thick liquids, honey thick, solids and puree. At that time, strict NPO with use of the PEG as the primary source of nutrition/hydration/medications re recommended. PEG tube was removed since that time and pt has resumed a p.o. diet. Pt's sister reported they instruct the pt to take small bites and small sips. Pt states that she does not want the PEG tube replaced at this time. VFSS was completed to assess pharyngeal phase of swallow. Pt presented with poor head positioning secondary to torticollis . The VFSS reflected R21 tolerated puree and solid food with no food that entered the airway. The VFSS reflected, Recommendations: Diet consistency recommendations: NPO; Liquid consistency recommendations: NPO .Swallowing Recommendation bedside: Dysphasia treatment .Comment: Suggest GI consult for consideration of long-term, alternate means of nutrition, hydration, medications if medically appropriate and within pt's POC[plan of care]. Pt may have small bites of puree or solid consistency foods for comfort/pleasure feeds. Swallow Precautions .1:1 .upright 90 degree .small bites of food . Review of R21 Physician History and Physical, dated 4/19/24, reflected, Patient is a [AGE] year old female with past medical history of Overactive bladder, Hemorrhoids, GERD, Lumbar disc disease, Bipolar disorder, COPD who was recently hospitalized for altered mental status with UTI and aspiration pneumonia. She was treated with iv abx, failed video swallow evaluation and PEG tube was inserted on 4/15/24. Patient has been discharged to [name skilled nursing facility] for rehab and continued medical care. Today she denies abdominal pain. No n/v, tolerating tube feeds. Still confused but per family at bedside more alert today than she has been . Review of R21 hospital discharge documents, dated 4/16/24, reflected Physician Progress notes that included,4/15/24 .She[R21] continues to refuse PEG tube. Education given regarding aspiration. She reports her previous PEG was painful. Sister is DPOA and had given consent per RN. Sister requesting second opinion by ENT-will consult. 4/16/24 .PEG placed yesterday .Assessment/Plan .Dysphasia History of PEG in 4/2023 s/p removal 2/2024 due to pain, Failed video swallow. SLP recommending NPO - small bites of pureed or solid foods for comfort/pleasure but no liquids. S/p PEG 4/15. ENT consult for second opinion per family request . Review of the, Statement of Capacity document, dated 4/20/24, reflected R21 had been determined unable to make her informed medical decisions. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R21's Activated Advanced Directive Document, dated 12/20/10, reflected R21's family member P was R21's responsible party. Continued review of the Document reflected, If I regain my ability to participate in medical treatment decisions, my designation of a patient advocate is suspended by may become effective again if I am subsequently determined to be unable to participate in medical decisions .Agent's Powers. I grand my Agent full authority to make decisions for me regarding my health care. I intend for may Agent to have the same authority to exercise my rights of liberty and self-determination that I have while I am competent. In exercising this authority, my Agent shall follow my expressed wishes, either written or oral, regarding my medical treatment. In making any decision, my Agent should first try to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent can not determine the choice I would want made based on my written or oral statements then my Agent shall choose for me based on what my Agent believes to be in by best interest .Statement of Desires Regarding the Use of Life Support. I do not wish to receive or to continue to receive medical treatment that will only postpone the moment of my death from an incurable and terminal condition or that will prolong an irreversible coma. I instruct all persons and entities involved with my medical care not to initiate medical treatment in such circumstances or not to continue such treatment if it has already been begun. I intend to include the artificial delivery of food and water(by means of nasogastric tube or tube into the stomach, intestines, or veins) as medical treatment that may be withheld or withdrawn under the conditions given above. I do not object to receiving any treatments that is merely intended to keep me as comfortable and free from pain as is reasonable possible, even if receiving such treatments could hasten the moment of my death .Terminal Condition means a condition that is reasonable expected to result in death within one month, with or without medical treatment . During an interview on 5/31/24 at 12:00 PM, Speech Therapist(ST) Q reported completed R21 speech therapy evaluation 4/19/24 for dysphasia therapy. ST Q reported R21 had history of swallowing issues and was nothing by mouth(NPO) 11/2023 while living at group home and choice was made to not follow dietary restrictions. ST Q reported admitted to the hospital April of 2024 with aspiration pneumonia. ST Q reported R21 had expressed desire to eat food but reported with R21 history of aspiration pneumonia and failed swallow study it was not safe for resident or staff. ST Q reported R21 failed the swallow evaluation in April 2024 at the hospital(liquids only according to VFSS noted above) and after discussion with the Medical Director decision was made for R21 to remain NPO and discharge from speech therapy on 4/25/24. ST Q and Therapy Manager(TM) R verified, after review of R21 medical record that R21 was her own responsible party according to the facility face sheet and reported R21's sister was very involved. When asked if R21 had the right to make bad decisions including not following Physician order diet recommendations, TM R reported the facility did not offer waivers. ST Q reported R21 was seen for Ear, Nose and Throat(ENT) Physician consult on 5/29/24 as ordered by hospital who recommenced Speech Evaluation at the facility and swallow evaluation at large hospital in [NAME] Arbor. ST Q reported had started evaluation on 5/30/24 and given R21 2 bites of magic cup when X-ray arrived to perform ordered chest X-ray. ST Q reported evaluation was stopped and waited for results. ST Q R21 X-ray was negative and planned to re-evaluate R21 today. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/31/24 at 2:55 PM, Registered Dietician(RD) S reported facility policy to complete dietary evaluations on new admissions within 7 days of admission including Tube Fed NPO residents. Dietician S verified R21 was first assessed for nutritional assessment on 4/25/24(7 days after admission). Dietician S reported residents are then seen monthly. Dietician S reported R21 had several changes with Tube Feed type related to abnormal labs and reported believed inaccurate weights from the hospital contributed to what appeared to be weight loss. RD S reported physician group asked RD S yesterday to add pleasure feed for R21 because she asked for ice cream and verified note was not in R21 medical record. Review of the Speech Therapy Evaluation, dated 4/19/24, reflected R21 was seen for dysphasia therapy with plan to continue therapy five times weekly for four weeks to treat for swallowing dysfunction and/or oral function for feeding and evaluation of oral and pharyngeal swallow function. The Evaluation included R21 goals that included, I want to eat something. Review of the ENT Consult, dated 5/22/24, reflected R21 was seen for dysphasia and note indicated, Today's videostroboscopy was unremarkable .Recommend swallow therapy as well as swallow study at [named university] for re-evaluation of her swallow. Review of R21's, Report of Consultation, dated 5/22/24, revealed ENT completed note that reflected, swallow therapy based on April 2024 swallow study. (ST Q started R21 evaluation 5/30/24). Review of R21 Interdisciplinary Therapy Screen, dated 5/31/24, revealed nutrition swallow notes that reflected, Patient was seen for a Speech/Dysphasia screen effective 5/30/24 based on an ENT request. Patient was seen by an ENT 5/29/24 who recommended a swallow therapy and a swallow study at U Of M. A screen was initiated effective 5/30/24 but was suddenly discontinued as x-ray was in bldg to conduct a chest x-ray. SLP informed patient and sister the screen and or eval if warranted will be re-initiated 5/31/24 pending chest - x-ray results . (Speech evaluation was ordered 5/22/24 per ENT consult on 5/22/24). Review of R21 Provider Progress Note, dated 5/31/24, reflected, Patient seen for follow up on respiratory status. Much better today and her spirits are much better, as she was told she can start with small bites of magic cup. X-ray was negative. Discussed with speech therapist as well . Review of R21 Dietary Note, dated 5/31/2024 at 3:39 p.m., reflected, N.O.[nurse order] for magic cup daily with nsg supervision and assist when up in w/c for pleasure. [named provider group] came to RD office yesterday am 2/2 guest v/o sadness about not eating and really wanted ice cream and c/o tummy grumbling and hunger when TF[tube feeding] not infusing. Writer f/u with SLP about issue. Guest, her sister, [NAME], SLP and writer met and SLP trialed magic cup with guest with tactile/visual observation of swallow while guest was trying small bite of magic cup. (Note written after interview with Registered Dietician S on 5/31/24 at 2:55 p.m. During an observation and interview on 6/04/24 at 11:58 am, R21 was sitting in room, appeared to be in good mood and able to answer questions without difficulty. R21 reported had ask several staff since facility admission for something by mouth but was repeated told no that made her sad because she just wanted to eat something. R21 reported family P assisted her with medical choices and permission given to contact. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility, Skilled Care Note, dated 4/19/24 through 6/4/24, reflected R21's level of consciousness was documented as alert and not confused for 36 of 51 assessments. During an interview on 6/04/24 at 12:11 PM, ST Q verified had seen R21 on 4/19/24 with plans to see R21 for dysphasia treatment for several weeks and ended up seeing R21 for 4 total visits including evaluation and discharge within one week. ST Q reported had determined within first week that R21 was not going to progress related to poor condition and failed swallow evaluation at hospital and spoke with Medical Director and was her professional opinion that R21 should remain NPO. ST Q reported R21 sister pursued ENT consult that ordered additional ST evaluation and swallow evaluation at the University Hospital. During a telephone interview on 6/04/24 at 12:41 PM, R21 family P reported was R21 Medical Power of Attorney(DPOA) and assisted R21 with medical choices. R21 family P reported R21 did not want Feeding Tube placed in hospital but decision was made to place and wait for second opinion from ENT. R21 DPOA P reported when R21 was admitted to the facility was discharged from speech therapy within first week because of Medical Director went by Speech Therapy recommendations and swallow evaluation at hospital. R21 DPOA P reported swallow evaluation at hospital indicated R21 could have small bites of puree or solid food by mouth. R21 DPOA P reported ENT consult re-ordered speech evaluation and plans to send R21 to University Hospital for additional swallow evaluation. R21 DPOA P reported R21 should have the right to follow Physician orders including diet orders if fully informed of risk and benefits and was not given that right. R21 DPOA P reported feels R21 was able to understand the the risks involved. R21 DPOA P reported R21 failed a swallow evaluation in November 2023 and made choice to continue to take food by mouth, against physician recommendations, and developed pneumonia, but it was her choice and her right. Review of the facility, Michigan Resident Rights & Facility Responsibilities, dated 2018, located in the facility resident admission packet, reflected, Refusal of Treatment. A patient or resident is entitled to refuse treatment to the extent provided by law and to be informed of the consequences of that refusal of treatment. If a refusal of treatment prevents a health facility or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient or resident may be terminated upon reasonable notice . (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility, Federal Resident Rights & Facility Responsibilities document, undated, located in the resident admission packet, reflected, Resident Rights. The Resident has the right to dignified existence, self-determination, and communication with the access to persons and services inside and outside the facility .Dignity, Respect & Quality of Life. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident .Resident Representative .The resident's wishes and preferences must be considered in the exorcise of rights by the representative .To the extent practicable, the resident must be provided with opportunities to participate in the care planning process .Treatment Options and Alternatives. The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers .Refusal of Treatment. The right to request, refuse, and/or discontinue treatment . Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice .Health Care & Providers. The resident has the right to choose activities, schedules .health care and providers of health care services consistent with his or her interest, assessments, plan of care and other applicable provisions of this part. Significant Life Aspects. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident .Advance Directives. The facility must comply with the requirements .This includes a written description of the facility's policies to implement advance directives . During an interview on 6/04/24 at 1:30 PM, Nursing Home Administrator (NHA) A reported residents provided with resident rights as part of admission packet. When asked if resident or responsible party had the right or choice to follow physician diet orders, NHA A stated, Depends. When asked if residents or responsible party had the right to make bad decisions if given education related to the risk of choice, NHA A stated, depends. NHA A stated, who's rights are more important? One resident or several other residents who witness choking event. NHA A reported would they have to complete several trauma assessments on other residents if that occurred. NHA A reported would not be safe for resident to not follow physician diet orders or staff and stated, They have the right to transfer to another facility.

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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** 32064 Based on observation, interview, and record review, the facility failed to implement a comprehensive care plan for one resident (Resident #115) of 26 residents reviewed. Findings include: Resident #115: Review of the medical record revealed Resident #115 (R115) was admitted to the facility on [DATE] with diagnoses that included moderate protein-calorie malnutrition. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/18/24 revealed R115 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R115's medical record revealed they had a pressure ulcer to their coccyx and left heel. On 05/30/24 at 1:29 PM, R115 was observed in their room, reclined in a high back wheelchair. R115 appeared to be sliding out of the wheelchair. R115 reported they had wounds on their bottom and their heel. R115 reported their bottom hurts horrible. There was a wheelchair cushion and dycem (non-slip material) observed on the bed and not in the wheelchair. At 1:34 PM, Certified Nursing Assistant (CNA) D and CNA E entered the room to transfer R115 back to bed. They reported R115 had been in their wheelchair since approximately 11:40 AM. When R115 was transferred to bed via a Hoyer lift, it was confirmed there was no cushion in R115's wheelchair. Protective boots were put on R115's feet. Review of R115's care plans revealed an intervention dated 2/22/24 for pressure reduction cushion to wheelchair or chair. There was no mention of dycem. Review of R115's Kardex (CNA care guide) revealed no mention of a wheelchair cushion or dycem. On 05/31/24 at 9:14 AM, R115 was observed in bed, lying on their back. R115's heels were not elevated and there were not any boots in place. R115's heels were resting directly on the mattress. At 9:15 AM, CNA F was observed providing care alone to R115 which included rolling side to side bed mobility and changing their brief. CNA F did not float R115's heel or place the boots on R115's feet. Review of the Kardex revealed encourage to float heels on pillow or wear heel protectors while in bed and Bed mobility: Resident is dependent with 2 helpers. This is including rolling side to side, lying to sitting on side of bed and sitting to lying. On 05/31/24 at 10:47 AM, R115 was observed in bed, positioned on their right side. R115 did not have boots on their feet and their heels were not floated. On 05/31/24 at 11:23 AM, R115 was observed in the same position. (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 interview on 06/04/24 at 8:58 AM, Registered Nurse (RN) C reported they were the Unit Manager. RN C reported when in bed and on their back, R115 should have on boots, or their heels elevated. RN C reported R115 was to have a cushion when up in their wheelchair. RN C reported the cushion was on the care plan, but not linked to the Kardex, therefore, the CNA's would not have that information available. RN C agreed R115's care plan reflected they were a two person assist with bed mobility but reported that could be changed to one person.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34705 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the carpet in room [ROOM NUMBER], resulting in the increased likelihood for cross-contamination, bacterial harborage, odor and decreased air quality. Finding include: During an interview on 5/30/24 at 2:10 PM, Confidential Family Member(CFM) T reported that a loved one was originally admitted into room [ROOM NUMBER] that had carpet and had very strong odor of urine. CFM T reported loved one was moved out of the room, however, another resident is currently in room and odor was still present and reported felt sorry for resident. During tour of facility on 6/04/24 at 10:20 AM, very strong pungent odor of urine noted outside room [ROOM NUMBER]. room [ROOM NUMBER] was noted to have carpet on floor. During an interview on 6/04/24 at 10:25 AM, Housekeeping staff (HK) U reported had worked at the facility for about three years. HK U reported history of foul odor in areas with old carpet because odor can not be removed from carpet. HK U reported odor from old carpets are horrible and staff shampoo three times weekly and does not improve. HK U reported staff reported concerns to TELS system (maintenance work log) and believe facility has been converting rooms from carpet to hard surface. During an observation on 6/04/24 at 10:36 AM, continued very strong odor noted at nurse station, located about 15 feet from room [ROOM NUMBER]. During an interview and observation on 6/04/24 at 10:54 AM, Maintenance Director(MD) V entered room [ROOM NUMBER] and verified odor. MD V reported no knowledge of prior complaints and would follow up after reviewing TELS system. During an interview on 6/04/24 at 11:09 AM, MD V returned and reported complaint was reported yesterday in TELS related to odor in room. MD V reported would follow up with additional complaints prior to yesterday. During an interview and record review on 6/04/24 at 11:28 AM, MD V provided past two month for room [ROOM NUMBER] of TELS reports. MD V reported odor in room [ROOM NUMBER] was reported 5/18/24 by different family than 6/3/24. MD V reported did not receive grievance forms and would have. MD V reported tells closed concern 4/19/24 after floor shampooed and reported unable to show proof room [ROOM NUMBER] was shampooed on 4/19/24 and no follow-up system in place except to wait for additional complaints. During an interview on 6/04/24 at 11:45 AM, MD V reported created log for carpet cleaning staff to record completed rooms moving forward. MD V was observed with staff with carpet cleaner in hall and reported had just shampooed room [ROOM NUMBER]. MD V reported corporate gives approval for carpet removal to had floor and room [ROOM NUMBER] the list. MD V verified shampooing room [ROOM NUMBER] did not correct the odor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/04/24 at 11:50 am, room [ROOM NUMBER] continued to have very strong odor of urine and faint smell of chemicals and air felt humid. During an interview on 6/04/24 at 1:30 PM, Nursing Home Administrator (NHA), A reported plan to remove carpet from room [ROOM NUMBER] as soon as possible. MD A reported unable to change all rooms at one time but would make sure room [ROOM NUMBER] was on the list. MD V reported facility had attempted to replace long term resident carpet prior to short term. MD V reported was unsure why a grievance form not completed for either family complaint on 5/18/24 or 6/3/24 related to same issue.