

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/12/2024
NAME OF PROVIDER OR SUPPLIER  Regency at Shelby Township		STREET ADDRESS, CITY, STATE, ZIP CODE  7401 22 Mile Road Shelby Township, MI 48317	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49102</p> <p>Based on interview, and record review, the facility failed to ensure one resident (R25) was catheterized (straight cathed-tube inserted into the bladder to help drain urine) timely out of one reviewed for dignity, resulting in the potential for feelings of sadness. Findings include:</p> <p>On 09/11/24 at 2:27 PM, an interview with R25 occurred and R25 stated Because I am one of the youngest ones here, I try not to cause trouble. I was up by 5:00 AM and cathed for my doctor's appointment. Upon returning from the appointment at 1:00 PM, I asked the nurse to cath me again because it was hurting. I had to wait until 3:00 PM. I was really upset and sad about waiting so long to be cathed. It made me feel sad like the nurses don't care about me or how I feel.</p> <p>A review of R25 medical record revealed they were admitted into the facility on [DATE] with diagnoses of Scoliosis, Insomnia, Hypertension, and Neuromuscular Dysfunction of Bladder. A review of R25's Minimum Data Set (MDS) assessment dated [DATE] revealed, R25's Brief Interview for Mental Status assessment score was a15 indicating intact cognition.</p> <p>On 09/12/24 at 12:25 PM, an interview occurred with the Director of Nursing (DON) regarding the expectations of residents rights regarding dignity and care. The DON stated, It is my expectation the resident needs would be cared for once they asked for assistance</p> <p>A review of the policy titled Resident Rights and Facility Responsibilities dated 9/01/13 and revised 5/14/24 revealed Dignity, Respect &amp; 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.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207</b></p> <p>Based on observation, interview, and record review, the facility failed to provide one resident (R56) of three residents reviewed for accommodation of needs with a comfortable bed, resulting in feelings of dissatisfaction and discomfort. Findings include:</p> <p>On 9/10/24 at 2:58 PM, R56 was observed in bed with their feet on the end of the bed on the bed board, a pillow was underneath their feet. R56 was observed to be obese and their was very little room in the bed on either side of their body. R56 was interviewed about the comfort of their bed and indicated they were uncomfortable and dissatisfied with their bed. R56 stated, Can you talk to them about getting me a better bed.</p> <p>On 9/10/24 at 3:05 PM, Certified Nurse Assistant (CNAG) entered R56's to provide them with fresh water and was asked about R56's bed. CNA G stated, We need better beds.</p> <p>On 9/11/24 at 10:46 AM, R56 was observed in bed on their back with very little room in the bed on either side of their body. R56 stated, I cannot move in this bed. Once they put me in bed, I can't move. R56 again indicated they would like assistance with obtaining a more comfortable bed.</p> <p>On 9/11/24 at 12:35 PM, an interview was conducted with Nurse/RN (Registered Nurse) H regarding R56's bed and R56's discomfort with their bed. Nurse H stated, I don't know why [R56] doesn't have a bariatric bed (Heavy-duty bed wider than a standard hospital bed).</p> <p>On 9/11/24 at 2:20 PM, Unit Nurse Manager (UNM)/RN I was interviewed regarding R56's bed and the discomfort expressed by R56 regarding their bed. UNM I stated, I believe [R56] has a bariatric bed.</p> <p>On 9/11/24 at 4:33 PM, R56 was again visited in their room and was observed in bed on their back with very little room in the bed on either side of their body. R56 was further interviewed about their bed and stated, I need a bigger bed.</p> <p>On 9/11/24 at 4:44 PM, Environmental Services Director (ESD) J was interviewed about the bed in R56's room and indicated that R56's room was a bariatric room and should have a bariatric bed in it. EVS J and the surveyor then proceeded to go to R56's room and observed their bed. Upon observation of R56's bed, EVS J stated, That's not a bariatric bed. I'm going to have to look into that.</p> <p>On 9/12/24 at 10:37 AM, the Administrator (NHA) was interviewed regarding their expectations for ensuring that obese residents have comfortable beds and are comfortable when in bed. The NHA indicated that all beds in the facility are considered to be bariatric, It's by weight, not by dimension. The NHA was asked specifically about R56's bed and R56's expressed discomfort when in their bed. The NHA stated, Rolling (moving side to side) was the issue, we discussed a positioning bar for [R56]. We don't have a bigger bed, but are not opposed to it if necessary.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of R56's electronic medical record (EMR) revealed that R56 was admitted to the facility on [DATE] with diagnoses that included Morbid obesity and Muscle weakness. A review of R56's vitals revealed on 9/12/24 R56 was weighed and had a weight of 384 pounds. A review of R56's most recent minimum data set assessment (MDS) dated [DATE] revealed that R56 had an intact cognition and was dependent upon staff for all activities of daily living (ADLs).</p> <p>A review of a facility policy titled, Bariatric bed use Revised: May 20, 2024 revealed the following, Introduction: .Various types of bariatric beds are available, ranging from [a] simple larger version of the standard bed to a bed with a low air mattress that provides pressure relief. A bariatric bed provides more comfort for a patient with obesity then a standard-sized hospital bed. A bariatric bed also preserves the self-esteem of a patient with obesity by fitting the patient's larger body size easily and providing special side rails that help the patient with turning and repositioning .</p> <p>A review of the manufacture's product summary for Adjustable-width long-term care bed revealed the following, Product Description: The innovative [Product identification number] adjusts from 36 (Inches) to 39 to 42 .One bed can accommodate most residents in comfort safety, including many bariatric residents .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50223</p> <p>Based on observation, interview, and record review the facility failed to develop a comprehensive care plan for one (R103) out of six residents reviewed for care plans. Findings include:</p> <p>On 9/10/24 at 10:20 AM, 2:05 PM, and 4:22 PM, and on 9/11/24 at 8:29 AM, 9:52 AM, 12:05 PM, 1:23 PM, and at 4:22 PM, R103 was observed lying in bed and a back brace was observed in R103's room.</p> <p>On 9/12/24 at 8:49 AM, R103 was observed standing in the hallway with their walker. Certified Nurse Assistant (CNA) C stated, Where is your back brace, you need to have it on at all times. CNA C was then observed applying R103's back brace.</p> <p>A review of R103's medical record revealed they were admitted to the facility on [DATE] with a diagnosis of Wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing. A review of R103's Brief Interview for Mental Status revealed a score of four, indicating cognitive impairment.</p> <p>A review of R103's physician orders revealed an active order which documented, Lumbar brace when OOB (out of bed). Check skin integrity under brace q (every) shift. Report any abnormal findings to MD/NP (medical doctor/nurse practitioner).</p> <p>A review of R103's care plan and Kardex (guide to resident care) revealed no documentation of the back brace.</p> <p>On 9/11/24 at 12:00 PM, during an interview, CNA C was asked how they ensure they have accurate information about a resident and confirmed they use the Kardex which has information about their care.</p> <p>On 9/12/24 at 9:30 AM, during an interview, Licensed Practical Nurse (LPN) D was asked if R103 is supposed to wear a back brace. LPN D replied No, (they) are not. LPN D was asked how would they know if R103 was supposed to wear a back brace and said, I would look in the residents' careplan and if they are to wear a brace.</p> <p>On 9/12/24 at 11:30 AM, during an interview, the Director of Nursing (DON) was asked to review R103's orders and careplan and was asked if R103 is supposed to be wearing a back brace. The DON stated (R103) does have an order for one so yes (they) should be wearing it. The DON was reviewing R103's care plans and confirmed the back brace should be included in the care plan.</p> <p>A review of the facility's policy titled Care Planning stated the following: Every resident in the facility will have a person-centered plan of care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, a registered nurse who is responsible for the resident, a nurse aide, a member of food/nutrition services, the resident or resident representative, therapy staff as required and any other ancillary staff.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>49102</p> <p>Based on observation, interview, and record review, the facility failed to revise a care plan to reflect interventions for wandering behaviors for one resident (R76) out of one reviewed for behaviors. Findings include:</p> <p>On 9/10/24 at 10:13 AM, R76 was observed lying in bed sleeping soundly.</p> <p>On 9/10/24 at 4:00 PM, R76 was observed sitting up in bed watching television.</p> <p>On 9/10/24 during a confidential resident council, three residents discussed R76 wandering and behaviors at night. One resident stated, I have complained about (R76) coming into to room at all hours of the night. R76 doesnt pay attention to 'stop signs' on doors or if door is closed. I have to yell for the staff to come and help. R76 hits the staff and is difficult with them as well.</p> <p>A review of the record revealed R76 was admitted into the facility 02/05/24 with following diagnoses: Alzheimer's Disease, Dementia, Hyperlipidemia, Catatonic Schizophrenia and Depressive disorder. A review of the Minimum Data Set (MDS) assessments on 8/14/24 revealed, Brief Inverview Mental Status assessment score was 00 indicating severely impaired cognition.</p> <p>Further review of the active care plans revealed:</p> <p>-A care plan, (R76) is at risk for elopement and/or wandering R/T (related to) dementia initiated 02/05/24, revised 08/23/24 with no noted new interventions since 2/05/24.</p> <p>-A care plan, (R76) is at risk for decline in cognition and has impaired cognitive function or impaired thought processes r/t Alzheimer's, impaired decision making, poor safety awareness, inability to follow directions and short term memory loss care plan initiated 2/07/24 and last revised 03/07/24 was noted with no new interventions since 2/07/24. The care plan did not represent the intrusive behaviors identified.</p> <p>On 9/12/24 at 10:00 AM, along with Social Worker (SW) K a review of R76's care plans and interventions occurred. SW K stated interventions are discussed and used to try to keep R76 from going into other residents rooms and areas.</p> <p>On 9/12/24 at 12:26 PM, an interview with the Director of Nursing (DON) occurred and confirmed the interventions should be changed and be effective related to residents care plans.</p> <p>A review of the policy titled, Care Planning implemented 9/01/11 and revised 6/24/21, revealed, Every resident inthe facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that included measurable objectives and time framesto meet a residents medical, nursing, mental and psychosocial needs .The results of the interdisciplinary assessments will be used to develop, review and revise the residents care plans.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49102</p> <p>Based on observation, interview and record review, the facility failed to follow up on physician's orders to scheduled an appointment for one resident (R30) of one resident reviewed for consultation.</p> <p>Findings include:</p> <p>On 09/10/24 at 9:30 AM, R30 was observed sitting on the side of his bed watching television. When asked about concerns with care, R30 stated Yes. I have not seen the wound doctor lately due to my old sore and I have a rash on my side that really itches and burns.</p> <p>A review of R30's medical record revealed a physician's note dated 8/28/24 stating Resident was seen for the Chief Complaint: Requesting dermatology consult. Patient was seen today at their request for rash to the back of left hip and left groin. Resident also reports that it has been on the back for a long time, so this is not new for this patient. The areas appear round and raised, but no scaly or dry skin noted. Resident does report that they are itchy, sore and sometimes burns. They are very difficult to see. Resident states that the hydrocortisone cream did not help.</p> <p>On 9/11/24 at 10:05 AM, Charge Nurse L was queried about the order and its follow up and revealed they were not aware of any follow up appointments.</p> <p>On 9/11/24/at 12:55 PM, an interview occurred with Wound Care Nurse F who stated they did not know about the consult.</p> <p>On 9/11/24 at 1:00 PM an observation of R30 affected area was observed with Nurse F. The observation revealed that R30's whole back, arms and lower back were covered with a rash and several scaly areas.</p> <p>Further review of R30's medical record revealed they were admitted into the facility on [DATE] with diagnoses of Orthopedic Aftercare, Type 2 Diabetes, Hypertension; Sleep Apnea. A review of R30's Minimum Data Set (MDS) assessment dated [DATE] revealed R30's Brief Interview for Mental Status (BIMS) assessment score was a 10 indicating mildly impaired cognition.</p> <p>On 9/12/24 at 10:23 am, during an interview with the Director of Nursing (DON) stated, My expectation would be that the appointment would be made by the appropriate party and the residents care would be followed up on.</p> <p>A review of the policy titled Resident Rights and Facility Responsibilities dated 9/01/13 and revised 5/14/24 revealed A resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery in terms that the resident can understand .</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50223</p> <p>Based on observation, interview, and record review, the facility failed to provide services to maintain the functional abilities of one (R70) out of one resident reviewed. Findings include:</p> <p>On 9/10/24 at 9:34 AM, R70 was observed lying in bed. R70 was asked if they had any concerns about their care. R70 explained they can no longer get out of bed as much as they used to and now need help with bathing. R70 explained they were previously getting therapy which was helping them perform their hygiene care and they were getting stronger but now they are on restorative care but haven't been getting it and cannot do anything without help now.</p> <p>09/11/24 11:51 AM R70 was observed in the bathroom sitting in their wheelchair at the sink. R70 explained it takes them a long time to get washed up because they are much weaker since not receiving therapy.</p> <p>A review of R70s electronic medical record (EMR) revealed they were admitted to the facility on [DATE] with the following diagnosis: Hypothyroidism unspecified. A review of R70's Brief Interview for Mental Status revealed a score of 15 indicating intact cognition.</p> <p>A review of R70's physician orders dated 7/17/24 revealed the following: D/C (discontinue) skilled OT/PT (occupational therapy/physical therapy) tx (treatment) services and refer to RNP (restorative nursing program).</p> <p>A review of R70's therapy restorative program plan revealed the following: Restorative Plan Detail 1. Restorative Plan BUE (bilateral lower extremities)/LE (lower extremities) AROM (active range of motion) all available planes 15 reps x2 sets, 1 - 3x weekly for 12 weeks. 2. Date of Plan 08/02/2024 3. Goal(s) To maintain mobility and ADL (activities of daily living) function. 4. Interventions BUE/LE AROM all available planes 15 reps x2 sets, 1 - 3x weekly for 12 weeks.</p> <p>A review of R70's care plan revealed the following: (R70) is at risk for decline in function and requires Restorative Nursing r/t (related to) Impairment in range of motion. BLE AROM all available planes 15 repsx2 sets, 1-3x weekly for 12 weeks. BUE (bilateral upper extremity) AROM all available planes 15 reps x2 sets, 1-3 x weekly for 12 weeks.</p> <p>A review of R70's EMR task list revealed no documentation of receipt of restorative treatment.</p> <p>On 9/12/24 at 1:55 PM, during an interview with Physical Therapist (PT) E was asked if R70 was currently receiving therapy services. PT E explained R70 was not currently receiving physical or occupational therapy and R70 was discharged from physical and occupational therapy on 7/17/24 and was referred to the restorative nursing program to maintain contractures and limitations.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/12/24 at 2:20 PM, during an interview, Restorative Nurse F was asked if R70 was currently receiving restorative nursing services. Nurse F explained there are two Certified Nurse Assistants (CNAs) that perform the restorative services and they divide the residents amongst themselves and R70 was scheduled to be seen on Tuesdays, Thursdays, and Saturdays. Nurse F confirmed R70 only received restorative services one time within the 12-week period saying, I'm going to look into it.</p> <p>A review of the facility's policy titled Restorative Nursing revealed the following: Purpose: The facility strives to enable the resident to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being .Nursing restorative is available up to 6-7 times per week and is provided for residents meeting restorative program criteria .If resident refuses to participate then care needs will be managed by nursing and other clinical staff as indicated. Document any refusal in the resident's medical record .Document the resident's daily participation and actual number of minutes participating in the resident electronic health record.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44750</p> <p>Based on observation, interview, and record review, the facility failed to properly store an oxygen tank for one resident (R221) out of five reviewed for respiratory care. Findings Include:</p> <p>On 9/10/2024 at 10:20 AM, R221 was observed sitting in their room and was receiving oxygen via a nasal cannula. R221 stated they had recently arrived at the facility and needed oxygen continuously.</p> <p>In the corner of the room an oxygen tank was observed freestanding. No stand or cart was noted in the room.</p> <p>A review of the medical record revealed R22 admitted into the facility on [DATE] with the following medical diagnoses, Lung Cancer and Chronic Obstructive Pulmonary Disease (COPD). A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition.</p> <p>On 9/10/2024 at 10:31 AM, Certified Nursing Assistant (CNA) R was asked about the oxygen tank was in R221's room without a stand. CNA R stated they were going to get a stand immediately.</p> <p>A review of a facility policy titled, Oxygen Storage and Assembly noted the following, Oxygen Tank Safety . Store each tank individually, by a chain, on a cart, or on a stand.</p>

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44750</p> <p>Based on observation, interview, and record review, the facility failed to obtain physician orders for colostomy (an opening through the skin) care for one resident (R11) out of one reviewed for colostomy care. Findings include:</p> <p>On 9/10/2024 at 10:00 AM, R11 was observed laying in bed. R11 stated they were about to get up and get ready for lunch. R11 stated they needed their colostomy emptied. R11 stated they have had a colostomy for quite some time. R11 stated the staff does empty it, but they have to remind them.</p> <p>A review of the medical record revealed that R11 admitted into the facility on [DATE] with the following diagnoses, Chronic Respiratory Failure with Hypoxia and Major Depressive Disorder. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status score of 13/15 indicating an intact cognition. R11 also required staff assistance with bed mobility and transfers. The MDS assessment also noted R11 had an colostomy.</p> <p>Further review of the physician's order and task guide did not reveal an order for colostomy care, including changing.</p> <p>On 9/12/2024 at 12:13 PM, an interview was conducted with the Director of Nursing (DON). The DON confirmed R11 was admitted into the facility with a colostomy and stated R11 had been in and out of the hospital and their colostomy care orders must not have been reactivated.</p> <p>A review of a facility policy titled, Colostomy and Ileostomy, appliance care, long-term care did not mention colostomy care orders and task.</p>

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NAME OF PROVIDER OR SUPPLIER  Regency at Shelby Township		STREET ADDRESS, CITY, STATE, ZIP CODE  7401 22 Mile Road Shelby Township, MI 48317	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50223</p> <p>Based on observation, interview, and record review, the facility failed to provide ongoing behavioral health services for one resident (R27) out of eight reviewed for behavioral health. Findings include:</p> <p>On 9/10/24 at 10:00 AM, R27 was observed in bed. R27 explained they used to get out of bed into their wheelchair but does not feel like getting out of bed anymore because they are worried about their son whom they have been supporting financially and is now running out of money to support.</p> <p>On 9/11/24 at 11:24 AM, during an interview, Social Worker (SW) P was asked if they were aware of R27's mood and concerns regarding their son. SW P explained they were aware and they talked to accounts receivable and informed R27 of how much money was left over after they paid the facility. SW P also explained that they provided R27 with the name and phone number of a church and called R27's older son.</p> <p>On 9/12/24 at 11:59 AM, R27 was observed in bed awake with the blinds closed and staring at the wall. R27 was observed to be wearing the same clothes as observed on the previous day. When asked if they had breakfast yet R27 stated they did not feel like eating. R27 stated I feel very bad. I wish to die. I have no money to help my son and he tells me he will be on the street. When asked if they had been eating, R27 stated I eat a little bit. I wish to die today but Jesus Christ told me it's not my time. I ask him to take me away. I don't want to eat. I have no appetite most of the time. This is not your problem, but I have to talk to someone. I wish to die so I don't have to worry anymore. I wish to die. I wish to die. I wish to die. Please Jesus take me away. I am so tired of this life.</p> <p>A review of R27's record revealed they were admitted to the facility on [DATE] with the following diagnosis: pressure ulcer of sacral region; Anxiety disorder unspecified. A review of R27's Brief Interview for Mental Status revealed a score of 15 indicating intact cognition.</p> <p>A review of R27's progress notes revealed a nurses note dated 9/1/24 stated: Guest refused lunch this shift, (R27) is worried about (R27) son and (R27's) sons financial situation, notified social work.</p> <p>Further review of R27's record revealed a psychiatry note dated 7/5/24 stated He has obvious depression . demeanor: calm, pleasant, cooperative. Suicidal ideation: denies. Appetite: good. Notify of changes in mood or behaviors. Will follow. No other psychiatry notes or referrals were found.</p> <p>On 9/12/24 at 11:30 AM, during an interview the Director of Nursing (DON) they explained they (residents) should be seen as needed and for any concerning behaviors or anything out of the ordinary.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R27's care plan revealed the following: (R27) has the potential for fluctuation in mood r/t (related to) anxiety. Behavioral health/psych consults as needed and follow recommendations as indicated. Observed and report to SW and/or physician prn (as needed) acute changes in mood or behavior; feelings of sadness; increased anxiety/agitation, depression, withdrawal/loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills; how resident interacts with others.</p> <p>On 9/12/24 at 12:12 PM, Certified Nurse Assistant (CNA C) was asked if they were aware of R27s mood and explained they thought R27 was upset and had gotten into a fight with their son. CNA C explained R27 doesn't always seem this way and the depressed mood was new.</p> <p>A review of the facility's policy titled Behavior Management revealed the following: The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/functional programs as appropriate and safety interventions to minimize behaviors .7. Resident may require a referral to psychiatric/psychological services or spiritual care. 9. A Behavior Management meeting will be conducted monthly and PRN or at the resident at risk at least monthly, as needed by the interdisciplinary team and document any changes in the care plan at the meeting. Residents will be reviewed during the meeting are as follows: Residents identified with new or worsening behaviors (including mood changes).</p> <p>A review of the facility's policy titled Social Services Referral to Outside Providers revealed the following: Referrals to ancillary providers will be made to meet the psychosocial and or concrete needs of a resident while safeguarding protected health information .9. Follow up visits will be scheduled as needed. 10. The mood/behavior/psychosocial/trauma or substance abuse issues, that prompted the need for services, are to be monitored and the service provider is to be kept informed of the evaluation of progress.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</b></p> <p>Based on observation, interview, and record review, the facility failed to practice proper infection control practices in a contact isolation room and properly store nebulizer/C-Pap (non-rebreather) mask for five residents (R36, R223, R221, R74, and R11) reviewed for infection control. Findings include:</p> <p><b>R36</b></p> <p>On 9/10/2024 at 12:06 PM, the call light for R36 was seen activated. R36 was noted to be on contact precautions. A sign, as well as personal protective equipment (PPE) was observed on the door.</p> <p>On 9/10/2024 at 12:07 PM, Maintenance Assistant (MA) B was observed going into the room. MA B did not don/doff any PPE, nor perform hand hygiene upon exiting the room.</p> <p>A review of the medical record revealed R11 admitted into the facility on [DATE] with the following diagnoses, Chronic Respiratory Failure with Hypoxia and Major Depressive Disorder. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 13/15 indicating an intact cognition. R11 also required staff assistance with bed mobility and transfers.</p> <p>On 9/12/2024 at 9:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated anyone who goes into a contact isolation room should be wearing all PPE, including gowns, gloves, and a mask. The DON also stated hand hygiene should occur upon exiting.</p> <p>A review of a facility policy titled, Contact Precautions noted the following, Health care personnel caring for guests/residents on Contact Precautions should wear gloves and a gown for all interactions that may involve contact with the guest/resident or potentially contaminated areas in the guest's/resident's environment.</p> <p><b>R223</b></p> <p>On 9/10/2024 at 9:30 AM, R223 was observed in bed. R223 nebulizer mask was observed sitting n the nightstand. No barrier was observed between the mask and the nightstand. R223 stated they use the mask because they have lung cancer.</p> <p>On 9/10/2024 at 2:42 PM, R223's nebulizer mask was observed still sitting on the nightstand with no barrier in between it.</p> <p><b>R221</b></p> <p>On 9/10/2024 at 10:20 AM, R221 was observed sitting up in their wheelchair. Their nebulizer mask was observed laying on the nightstand with no barrier in between them.</p> <p><b>R74</b></p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/10/2024 at 9:20 AM, R74 was observed sitting in a chair. R74's C-Pap mask was observed laying on the nightstand with no barrier in between them.</p> <p>On 9/11/2024 at 10:20 AM and 11:52 AM, R74's C-Pap was observed laying on the nightstand with no barrier in between them.</p> <p>R11</p> <p>On 9/10/2024 at 10:00 PM, R11 was observed laying in bed. R11 stated they have been in and out of the hospital a few times for not wearing their C-pap mask. Their C-pap mask was observed on their bedside table with no barrier in between them.</p> <p>On 9/11/2024 at 12:27 PM, R11's C-Pap mask was observed laying on the bedside table with no barrier in between them.</p> <p>On 9/12/2024 at 8:42 AM, R11's C-Pap mask was observed laying on the bedside table with no barrier in between them.</p> <p>On 9/12/2024 at 9:50 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they have order sets for the nebulizer and c-pap mask for them to be cleaned. The DON stated they should be cleaned and set on a paper towel to dry and then put away once dry.</p> <p>A review of a facility policy titled, Noninvasive positive-pressure ventilation, respiratory therapy id not mention storage practices.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207</b></p> <p>Based on observation, interview, and record review, the facility failed to respond to residents needs(call lights) in a timely manner for one resident (R81 and R47) and two resident rooms (rooms [ROOM NUMBERS]) fourteen reviewed for call light response. Findings include:</p> <p><b>R81</b></p> <p>On 9/10/24 at 9:59 AM, R81 was interviewed in their room with their daughter present and ask about the care and services they were receiving at the facility. Both R81 and their daughter indicated that call light wait times, Can be long, up to forty five minutes during the early morning and on weekends.</p> <p>A review of R81's electronic medical record (EMR) revealed R81 was originally admitted to the facility on [DATE] with diagnoses that included, aftercare following knee joint prosthesis and weakness. R81's most recent minimum data set assessment (MDS) dated [DATE] revealed R81 had an intact cognition and required partial to moderate assistance with all activities of daily living (ADLs) other than eating and oral hygiene.</p> <p>On 9/12/24 at 3:15 PM, CNA M was interviewed and asked about their ability to respond to and meet resident care needs. CNA M stated, It can be challenging.</p> <p>09/12/24 03:25 PM, CNA O was interviewed about their ability to respond and meet resident care needs in a timely manner. CNA O stated, If we are fully staffed it's okay, if not then it's difficult. CNA O indicated they frequently work on units that are not fully staffed.</p> <p><b>44750</b></p> <p>On 9/11/2024 at 9:50 AM, the call light for room [ROOM NUMBER] was observed activated.</p> <p>At 10:00 AM, the light was still observed to be activated, the nurse for the hallway was observed at their cart.</p> <p>At 10:06 AM, the light was still observed to be activated and therapy staff was observed walking past the light.</p> <p>At 10:10 AM, the light was observed still activated and the nurse was noted to be in the hallway.</p> <p>At 10:13 AM, the light was answered by a Certified Nursing Assistant (CNA) and care was rendered.</p> <p><b>50223</b></p> <p><b>R47</b></p> <p>On 9/11/24 at 1:24 PM, call lights were observed to be on for rooms [ROOM NUMBER] (where R47 resided).</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 9/11/24 at 1:25 PM, a therapy staff member, an activities staff member, a Certified nurse assistant (CNA), and a nurse all walked passed all 3 lights. A vendor was observed to leave room [ROOM NUMBER] and went to the nurses station to inform them the resident in room [ROOM NUMBER] needed help.</p> <p>On 9/11/24 at 1:27 PM, the same nurse walked past all 3 call lights again.</p> <p>On 9/11/24 at 1:28 PM, the activities staff member walked past all 3 lights again.</p> <p>On 9/11/24 at 1:29 PM, the same nurse walked past again.</p> <p>On 9/11/24 at 1:29 PM, the Director of Nursing (DON) walked in to room [ROOM NUMBER] and turned the call light off.</p> <p>On 9/11/24 at 1:31 PM, a CNA turned off the light in room [ROOM NUMBER] and exited the room.</p> <p>On 9/11/24 at 1:33 PM, R47 in room [ROOM NUMBER] was yelling out nurse!. When asked if anyone addressed their needs when they turned the call light off R47 stated no. they just turned it off and I gave up on it. R47 said they were yelling because they needed help and no one answered.</p> <p>On 9/12/24 at 10:00 AM, during an interview, The Nursing Home Administrator (NHA) was asked about their expectations for staff when responding to resident needs and explained call lights should be answered within 15 to 30 minutes and explained that lengthy call light times and unanswered call lights is a known problem that has been brought to their attention in resident council repeatedly. The NHA explained the expectation is, all employees answer the lights.</p> <p>On 9/12/24 at 11:30AM, during an interview, the Director of Nursing (DON) said they hope for a prompt answer of call lights and everything is taken care of at that time. The DON explained everybody should be answering call lights.</p> <p>A review of the facility's policy titled Call Lights revealed the following: Call lights will be placed within the guests/residents reach and answered in a timely manner. 1. Identify the location and answer the guest/resident promptly. 2. Knock on the door, identify yourself and ask the guest/resident wat you can help them with. 3. Go to the location of the call light and turn off the light if you are able to meet the guest/resident request. 4. Do what the guest/resident requests of you, if permitted. If you are unsure go, ask the charge nurse. 5. When finished, turn the call light off an replace the call light within guests/resident's reach.</p>		