

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2024
NAME OF PROVIDER OR SUPPLIER  Regency Florence		STREET ADDRESS, CITY, STATE, ZIP CODE  1951 E. 21st Street Florence, OR 97439	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>38139</p> <p>Based on observation, interview and record review it was determined the facility failed to provide incontinence care for 3 of 3 dependent residents (#s 101, 102 and 103) reviewed for incontinence care. This placed residents at risk for unmet care needs. Findings include:</p> <p>1. Resident 101 was admitted to the facility in 2020, with diagnoses including dementia and Traumatic Brain Injury (TBI).</p> <p>Resident 101's 2/2/24 Annual MDS CAA for Urinary Incontinence revealed Resident 101 was frequently incontinent of urine and required extensive assistance for toilet use and total dependence for transfers. Resident 101 was dependent on staff for toileting hygiene and was always incontinent of bladder. The resident had mixed incontinence (urge and functional). The resident has a terminal illness. Staff were directed to maintain pride and dignity while giving personal care.</p> <p>Resident 101's care plan indicated the resident was at risk for ADL deficits related to weakness, decreased mobility, impulse disorder, dementia with behaviors and traumatic brain injury. Resident 101 was on a Check and Change toileting program. Staff were to check the resident every two hours and assist with toileting as needed.</p> <p>A Facility Reported Incident dated 5/18/22, claimed Staff 8 (CNA) failed to provide timely incontinent care and repositioning for Resident 101 on 5/18/22 between 9:10 AM and 12:30 PM.</p> <p>The facility's investigation dated 5/18/22, indicated Staff 8 failed to provide incontinence care and repositioning for the resident who was dependent on staff for ADL care. Staff 8 initially stated she had provided care but then changed her statement and stated no staff answered her call for assistance. Staff interviews revealed she did not call for assistance on the walkie-talkies and did not ask anyone in person. The facility concluded Staff 8 failed to provide the required assistance to the resident.</p> <p>A written statement dated 5/18/22, by Staff 3 (RCMA/LPN) indicated at 9:10 AM, she placed an audit card under Resident 101's left hip area. At approximately 12:30 PM she asked Staff 8 when did she last change and reposition Resident 101. Staff 8 stated at 10:50 AM. Staff 3 checked the resident and found the audit card was still in place under the resident and the resident was soaked. Staff 8 had not provided care for the resident.</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 385142
		If continuation sheet Page 1 of 3

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/23/24 at 2:15 PM, Staff 3 (RCMA/LPN) stated she was the charge nurse on 5/18/22 and Staff 8 told her she had changed the resident but Staff 3 stated the evidence showed she had not. Staff 3 stated Staff 8 did not ask her for assistance with the resident or she would have helped her.</p> <p>On 4/23/24 at 3:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed the lack of incontinence care for Resident 101 on 5/18/22.</p> <p>2. Resident 102 was admitted to the facility in 2016, with diagnoses including cerebral palsy (congenital disorder of movement, muscle tone, or posture), left sided hemiparesis (partial paralysis) and need for assistance with personal care.</p> <p>Resident 102's 12/3/23 Annual MDS CAA for Urinary Incontinence revealed at-risk diagnoses included: muscle weakness, lack of coordination, reduced mobility, general weakness, abnormality of gait and mobility. The resident had mixed urinary incontinence (urge, functional and overflow). The resident was always incontinent of bowel and bladder and was a 1-person staff assist with toilet hygiene.</p> <p>Resident 102's care plan dated 3/4/22, indicated the resident was on a Check and Change Toileting program. Staff were to check the resident every two hours and assist with toileting as needed.</p> <p>A Facility Reported Incident dated 5/13/22, claimed Staff 9 (NA) failed to provide appropriate ADL care to Resident 102 on 5/7/22. Staff 9 put a bath blanket under the resident instead of changing her/his wet bed sheets. Resident 102 was found with a wet spot under the bath blanket. No harm was found to the resident and an investigation was started.</p> <p>The facility's investigation dated 5/13/22, indicated Staff 4 (PCA) stated she worked the night shift (10:00 PM to 6:00 AM) on 5/7/22 and received report from Staff 9 who stated he had changed the resident at 9:15 PM. When she checked on the resident around 10:30 or 11:00 PM, she found the resident with the blanket underneath her/him which was wet and there was a wet spot under the blanket. The facility determined Resident 102 did not receive incontinence care appropriately or timely.</p> <p>On 4/24/24 at 11:04 AM, Staff 4 (PCA) stated it was not correct procedure to put a blanket underneath the resident instead of changing the resident's soiled bedding. The material of the blanket could cause skin breakdown. Staff 4 stated when she saw Resident 102's condition she went and got the charge nurse to assess her/him. Staff 4 and two other aides cleaned the resident up and changed the bedding. Resident 102 was soaked with urine and had dried bowel movement on her/his behind.</p> <p>On 4/23/24 at 11:43 AM, Resident 102 stated she/he did not remember the incident. Resident 102 said the staff took very good care of her/him.</p> <p>On 4/23/24 at 3:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed the lack of incontinence care for Resident 102 on 5/13/22.</p> <p>3. Resident 103 was admitted to the facility in 2018, with diagnoses including dementia and Traumatic Brain Injury (TBI).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 103's 11/24/2021 Admission MDS CAA for Urinary Incontinence indicated the resident was on end-of-life Hospice care. Factors contributing to the resident's incontinence included: anxiety, increased weakness, decreased mobility, increased need for ADL support, death and the dying process. The resident's incontinence appeared to be functional in nature with a decline expected.</p> <p>Resident 103's care plan dated 11/17/22, indicated the resident was on a Check and Change Toileting program. Staff were to check the resident every two hours and assist with toileting as needed. The resident was a 1-person staff assist for toileting.</p> <p>A Facility Reported Incident dated 5/13/22, claimed Staff 9 (NA) failed to provide appropriate ADL care to Resident 103 on 5/7/22. Staff 9 put a bath blanket under the resident instead of changing her/his soiled bed sheets. Resident 103 was found with wet spots under the bath blankets. No harm was found to the resident and an investigation was started.</p> <p>The facility's investigation dated 5/13/22, indicated Staff 4 (PCA) stated she worked the night shift (10:00 PM to 6:00 AM) on 5/7/22 and received report from Staff 9 who stated he had changed the resident at 9:15 PM. When she checked on the resident around 10:30 or 11:00 PM, she found the resident with the blanket underneath her/him which was wet and there was a wet spot under the blanket. The facility determined Resident 103 did not receive incontinence care appropriately or timely.</p> <p>On 4/24/24 at 11:04 AM, Staff 4 (PCA) stated it was not correct procedure to put a blanket underneath the resident instead of changing the resident's soiled bedding. The material of the blanket could cause skin breakdown. Staff 4 stated when she saw Resident 103's condition she went and got the charge nurse to assess her/him. Staff 4 and two other aides cleaned the resident up and changed the bedding. Resident 103 was soaked with urine and had dried bowel movement on her/his behind.</p> <p>On 4/23/24 at 11:15 AM, Resident 103 was found not to be interviewable for this investigation. The resident was lying in bed asleep. The resident was clean and groomed, there was clean bedding on the bed and there were no odors detected in the room.</p> <p>On 4/23/24 at 3:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed the lack of incontinence care for Resident 103 on 5/13/22.</p>		