STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385142	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Florence	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34703 Based on interview and record review it was determined the facility failed to thoroughly investigate allegations of abuse for 1 of 7 sampled residents (#94) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 94 admitted to the facility in 3/2024 with diagnoses including failure to thrive. On 9/23/24 a public complaint was received which alleged on 9/12/24 Resident 94 stated Staff 17 (Former Agency LPN) indicated she was going to administer her/him an extra dose of oxycodone beyond what was prescribed, laughed and walked out of the resident's room. Resident 94 stated she/he felt threatened, verbally abused, and the incident caused her/him increased anxiety. Resident 94 stated Staff 17 came to her/his room later and indicated she gave the resident an extra dose of oxycodone. Resident 94 stated she/he was extremely upset and scared. Resident 94 stated a couple hours later Staff 17 came back to her/his room and explained she administered an extra dose of oxycodone to another resident and not her/him, laughed, and walked out of her/his room. On 12/5/24 at 1:57 PM Staff 7 (CNA) stated on 9/12/24 Staff 17 explained to the resident she/he administered an extra dose of oxycodone. Resident 94 started to panic, became upset, and she/he thought she/he was going to die. Staff 7 stated after a couple hours Staff 17 came and told the resident she/he did not administer the extra dose of oxycodone to her/him but to another resident. The investigation for the above incident did not include witness statements, other resident interviews or interview of the alleged perpetrator. On 12/5/24 at 2:45 PM Staff 2 (DNS) acknowledged there was no witness statement for the 9/12/24 incident. Staff 2 acknowledged a thorough investigation was not completed for the incident that occurred on 9/12/24.

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34703 Based on observation, interview, and record review it was determined the facility failed to assess and monitor pressure ulcers for 2 of 2 sampled residents (#s 11 and 94) reviewed for pressure ulcers. This placed residents at risk for unassessed and unmet treatment needs. Findings include: 1. Resident 11 admitted to the facility in 1/2017 with diagnoses including dementia. a. An 10/18/24 New Pressure Injury Incident Report indicated Staff 15 (LPN) was completing wound care for Resident 11 and noticed a new pressure injury to the left heel. The heel tissue was purple in color, soft to the touch, and the skin was intact. Staff 15 stated Resident 11 did not have her/his feet elevated with a pillow. Staff 11 (NA) reported the resident was upset and kicked the pillow off the bed. An 8/28/24 Care Plan revealed staff were to float Resident 11's heels with pillows while she/he was in bed as she/he allowed. A review of Resident 11's medical record revealed a left heel facility-acquired pressure ulcer. There was no documentation in the resident's medical record the left heel wound was assessed or monitored. On 12/2/24 at 3:14 PM Resident 11 was observed lying in bed without a pillow under her/his feet. On 12/3/24 at 9:40 AM Resident 11 was observed lying in bed without a pillow under her/his feet. On 12/4/24 at 9:31 AM Resident 11 was observed lying in bed without a pillow under her/his feet. On 12/5/24 at 7:58 AM Resident 11 was observed lying in bed without a pillow under her/his feet. A review of Resident 11's medical record revealed no Skin and Wound Evaluations documents. On 12/5/24 at 9:51 AM Staff 10 (CNA) and Staff 11 (CNA) stated they were aware Resident 11 had bruising to her/his left heel. Staff 10 and Staff 11 stated they keep the resident's heels off the bed mattress by placing a pillow under her/his feet. Staff 11 stated the left heel bruise was new but he was not aware if nursing was treating the wound. On 12/6/24 at 10:00 AM Staff 2 (DNS) acknowledged there were no Skin and Wound Evaluation documents for the left heel pressure injury. 2. Resident 94 admitted to the facility in 3/2024 with diagnoses including diabetes. The 3/11/24 Admission MDS indicated Resident 94 was cognitively intact and had no pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An 4/16/24 New Skin Issue Incident Report revealed Resident 94 complained of pain in the back of her/his left thigh. Staff 16 (LPN) observed an area approximately 2 cm below the left buttocks approximately 0.3 cm x 0.4 cm. The area was red in color and the surrounding tissue was red. The root cause appeared to be Resident 94 had her/his catheter tubing under her/his thigh because that was where she/he thought the tubing was supposed to be placed. The tubing was readjusted and the resident was educated on placement of the tubing. No Skin and Wound Evaluation was initiated regarding the wound. A 5/4/24 Initial Skin Ulcer/Injury Measurement and Evaluation indicated Resident 94 had an unstageable (full thickness wound covered by a layer of dead tissue) facility-acquired pressure ulcer to her/his right heel. There was no incident report or investigation for the above incident. A 5/15/24 Progress Note indicated Resident 94 developed a pressure injury to her/his coccyx (tailbone). There was no incident report or investigation for the above incident. A review of Resident 94's medical record revealed no Skin and Wound Evaluation documents relative to the above new pressure-related skin injuries. On 12/3/24 at 1:10 PM Resident 94 stated she/he had a left hip pressure ulcer which was painful, and staff did not assist her/him to reposition in bed. Resident 94 stated after the pressure wound developed staff assisted her/him with repositioning in bed. On 12/5/24 at 1:57 PM Staff 7 (CNA) and Staff 14 (CNA) stated the resident developed pressure wounds to the buttocks and hip area and to her/his heels. Staff 7 stated he repositioned the resident often and placed pillows under Resident 94's feet while in bed but the resident had leg spasms and accidentally kicked the pillows off the bed. On 12/6/24 at 10:00 AM Staff 2 (DNS) acknowledged there were no Skin and Wound Evaluations for the new left thigh and buttocks injury, right heel injury, and the coccyx injury, the new skin injuries were not investigated, and Resident 94's care plan was not updated

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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. 47001 Based on interview and record review it was determined the facility failed to monitor residents at risk for elopement and follow care plans related to safety for 2 of 6 sampled residents (#s 8 and 93) reviewed for accidents. This placed residents at risk for accidents. Findings include: 1. Resident 8 admitted to the facility in 2/2019 with diagnoses including dementia. A 3/24/24 Quarterly MDS indicated Resident 8 had severe cognitive deficits. A 3/28/24 Elopement Evaluation indicated Resident 8 was at risk for elopement. A 5/5/24 Progress Note indicated Resident 8 attempted to leave the facility four times in the evening before eloping at approximately 5:30 PM. Resident 8 was found outside, on the side of the road near the facility. Resident 8 fell out of her/his wheelchair and was assisted by individuals that were passing by. On 12/5/24 at 1:13 PM Staff 6 (CNA) stated Resident 8 was an active exit seeker prior to her/his elopement on 5/5/24. Staff 6 stated Resident 8 figured out the door code and attempted to leave the facility by entering in the door code. On 12/5/24 at 2:00 PM Staff 5 (LPN) stated on 5/5/24 Resident 8 stated she/he wanted to go out and feed her/his dog and during the evening of 5/5/24 Resident 8 continued to exit-seek between the front door and the back door trying to get out of the facility. Staff 5 stated facility staff attempted to keep an eye on Resident 8, but she/he successfully eloped from the facility and Staff 5 found Resident 8 on the sidewalk after she/he fell out of her/his wheelchair. On 12/5/24 at 2:01 PM Staff 7 (CNA) stated on 5/5/24, prior to Resident 8's elopement, he observed Resident 8 enter the door code and attempt to exit the facility. Staff 7 was able to intervene and keep Resident 8 from exiting the facility. On 12/6/24 at 10:46 AM Staff 1 (Administrator) acknowledged Resident 8 was an active exit seeker prior to the elopement on 5/5/24 and stated Resident 8 should have been placed on one-to-one supervision to prevent the elopement. 2. Resident 93 admitted to the facility in 7/2024 with diagnoses including diabetes. A 7/8/24 Care Plan revealed Resident 93 was care planned for one person assist while showering. A 7/25/24 public complaint indicated Resident 93 was left alone while taking a shower. On 12/3/24 at 5:06 PM Resident 93 stated a nurse left her/him alone in the shower which caused Resident 93 to feel frightened of falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/24 at 8:18 AM Staff 3 (Social Service Director) stated Resident 93 informed her she/he was left alone in the shower, but she/he declined to fill out a grievance form. On 12/6/24 at 11:06 AM Staff 4 (Agency LPN) acknowledged she left Resident 93 in the shower alone for approximately 10 minutes. On 12/6/24 at 10:46 AM Staff 1 (Administrator) stated residents were not to be left alone in the shower unless they were independent and approved by therapy to be left alone in the shower. Staff 1 acknowledged Resident 93 was not approved to be left alone in the shower.