

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 03/26/2025
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 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>38139</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders for therapy, failed to provide incontinence care and failed to ensure a call light was accessible for 2 of 3 sampled residents (#s 102 and 104) reviewed for quality of care and treatment. This placed residents at risk for unmet care needs. Findings include:</p> <p>1. Resident 102 was admitted to the facility in 2024, with diagnoses including stroke and diabetes.</p> <p>Resident 102's Admission Orders dated 9/12/24 included orders for Physical and Occupational Therapy.</p> <p>On 3/25/25 at 1:34 PM, Staff 15 (OT/Therapy Manager) stated the resident was not seen for therapy as they had not received therapy orders.</p> <p>On 3/26/25 at 3:40 PM, Witness 1 (Family Member) stated the resident was admitted to the nursing facility for Respite Care (temporary relief for caregivers of individuals with chronic illness, disabilities, or special needs) in 9/2024. The resident's PCP included orders for PT and OT but the resident did not receive any therapy while at the facility.</p> <p>On 3/27/25 at 3:36 PM, Staff 1 (Administrator) indicated she was unable to locate any documentation to explain why the resident did not receive the ordered therapy during the nine days the resident was at the facility.</p> <p>2. Resident 104 was admitted to the facility in 2024, with diagnoses including a Stage 4 pressure ulcer (most severe pressure wound with skin and tissue loss and exposed underlying structures like muscle, tendon, or bone) and quadriplegia-incomplete (partial paralysis of all four limbs resulting from a spinal cord injury or disease).</p> <p>A Facility Reported Incident dated 6/17/24 for an incident which occurred on 6/15/24 indicated Resident 104 was not provided incontinence care during the night shift, was found soiled in the morning, and her/his call light was on the floor out of the resident's reach. An investigation was conducted which determined the resident was left without cares through the night by Staff 16 (CNA). Staff 16 was terminated.</p> <p>Staff 16 did not respond to interview attempts on 3/24/25 and 3/25/25.</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
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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>On 3/24/25 at 11:58 AM, Staff 8 (CNA) indicated she went in to bring the resident breakfast on 6/16/24 and found the resident hanging half way off the bed and covered in feces. Staff stated she cleaned the resident and took her/him to the shower. Staff 8 stated the resident told her Staff 16 and another CNA had started to change her/him last night and had taken off her/his brief. Staff 8 stated the resident told her the CNAs would be back to finish changing her/him but no one ever came back. Staff 8 stated she found the wipes and a brief still on the bed. Staff 8 stated the resident stated Staff 16 had not been back to the room for the rest of the night shift.</p> <p>On 3/24/25 at 2:10 PM, Staff 2 (DNS) indicated their investigation determined Staff 16 did not provide appropriate care to Resident 104.</p>		