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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 47001 Based on interview and record review it was determined the facility failed to obtain consent prior to administration of a vaccine for 1 of 5 sampled residents (#1) reviewed for immunizations. This placed residents at risk for lack of informed consent. Findings include: Resident 1 admitted to the facility in 4/2024 with diagnoses including depression. A 12/4/24 review of immunizations revealed Resident 1 received a COVID-19 vaccine on 5/9/24. A 12/4/24 review of Resident 1's medical record revealed no evidence of a COVID-19 vaccine consent. On 12/6/24 at 10:46 AM Staff 2 (DNS) stated she was unable to locate a signed consent for the COVID-19 vaccine Resident 1 received on 5/9/24.

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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 34703 Based on interview and record review it was determined the facility failed to obtain information related to advance directives and health care decisions for 1 of 3 sampled residents (#30) reviewed for advance directives. This placed residents at risk for not having health care decisions honored. Findings include: Resident 30 admitted to the facility in 10/2021 with diagnoses including stroke. 5/23/23, 2/8/24, 2/22/24, 5/23/24 and 8/22/24 Interdisciplinary Care Conference notes revealed Resident 30 did not have an advance directive, but wanted one offered. Review of Resident 30's electronic record revealed no advance directive. On 12/3/24 at 9:43 AM Resident 30 stated she/he attended Care Conferences, but was not offered an advance directive. On 12/4/24 at 9:47 AM Staff 3 (Social Service Director) stated she offered advance directives at care conferences, and had the resident sign an Admission Assessment document to verify they received the advance directive. Staff 3 stated she did not conduct follow up related to provision of advance directives. On 12/5/24 at Staff 1 (Administrator) stated she expected staff to follow up before quarterly care conferences regarding advance directives.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50897 Based on interview and record review the facility failed to follow doctor's orders for 1 of 5 sampled residents (#24) reviewed for unnecessary medications. This placed residents at risk for receiving unnecessary medications. Findings include: Resident 24 admitted on [DATE] with diagnoses including heart disease. A review of Resident 24's medication orders revealed orders for Ipratropium-Albuterol Inhalation Solution (a medication to treat shortness of breath) for five days beginning 11/22/24. A review of Resident 24's 11/2024 and 12/2024 MARs also revealed the medication should be discontinued after five days on 11/27/24, however the MAR indicated the medication was administered through 12/4/24. In an interview on 12/4/24 at 4:00 PM Staff 2 (DNS) acknowledged the record showed Resident 24 continued to be given doses of Ipratropium-Albuterol Inhalation Solution for seven days past the date the medication was ordered to be discontinued.

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 47001 Based on interview and record review it was determined the facility failed to address orders for corrective lenses for 1 of 2 sampled residents (#1) reviewed for vision. This placed residents at risk for unmet vision needs. Findings include: Resident 1 admitted to the facility in 4/2024 with diagnoses including depression. A 6/3/24 Encounter Summary revealed Resident 1 saw an optometrist on 6/3/24 and a prescription was written for glasses. On 12/2/24 at 2:51 PM Resident 1 stated she/he went to an eye exam about six months previously and was supposed to get glasses, but did not. On 12/4/24 at 8:48 AM Staff 3 (Social Service Director) stated Resident 1 had her/his eyes checked on 6/3/24 but was unaware of the order for new glasses. On 12/4/24 at 2:04 PM Staff 2 (DNS) stated Resident 1 had an order for glasses but did not receive new glasses. Staff 2 acknowledged Resident 1 did not receive timely follow up for new glasses.

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 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)

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 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

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 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)

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 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.

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 34703 Based on interview and record review it was determined the facility failed to ensure provision of trauma-informed care for 2 of 2 sampled residents (#s 11 and 30) reviewed for behavioral needs. This placed residents at risk for unmet trauma needs and a decreased quality of life. Findings include: 1. Resident 11 admitted to the facility in 1/2017 with diagnoses including bipolar disorder, mood disturbance, communication deficit and post-traumatic stress disorder (PTSD). An 10/21/24 Annual MDS revealed Resident 11's BIMS score was five which indicated she/he had severe cognitive impairment. Resident 11 had little interest or pleasure in doing things, felt down, depressed, or hopeless, had trouble with sleep, felt tired, had eating difficulties, felt bad about herself/himself, trouble concentrating and moving and spoke slowly. A review of Resident 11's 11/8/24 care plan revealed areas which discussed trauma. All areas listed a history of trauma from the Vietnam War with history of a gunshot wound. There were no specific triggers related to Resident 11's PTSD or interventions included in her/his care plan. On 12/3/24 at 9:40 AM Resident 11 stated loud noises make her/him upset and scared and she/he experienced bad dreams. On 12/4/24 at 9:51 AM Staff 10 (CNA) and Staff 11 (CNA) stated Resident 11 could become upset and could be combative. Staff 10 and Staff 11 stated they did not know the resident had PTSD or what her/his triggers were. On 12/5/24 at 8:02 AM Staff 2 (DNS) stated Resident 11 had PTSD from the war and getting shot and she/he was not care planned for her/his specific trauma triggers or interventions. 2. Resident 30 admitted to the facility in 11/2021 with diagnoses including post-traumatic stress disorder (PTSD), stroke, depression, mood disorder, and suicidal ideations. A 11/15/24 Annual MDS revealed Resident 30's BIMS score was 15 which indicated she/he was cognitively intact. A review of Resident 30's 11/20/24 care plan revealed areas which discussed depression and self-harm. No areas spoke of Resident 30's history of abuse. There were no specific triggers or interventions included in her/his care plan. On 12/3/24 at 9:43 AM Resident 30 stated she/he had a history of abuse and her/his triggers included people yelling, or when male staff members came into her/his room. Resident 30 stated nobody asked her/him what her/his triggers were. On 12/4/24 at 9:51 AM Staff 9 (CNA) and Staff 11 (CNA) stated they were not aware Resident 30 had PTSD or what her/his triggers were. (continued on next page)

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 8:02 AM Staff 2 (DNS) stated Resident 30 had PTSD from a history of abuse and she/he was not care planned for her/his specific trauma triggers or interventions.

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47001 Based on interview and record review it was determined the facility failed to address pharmacy recommendations for 2 of 5 sampled residents (#s 1 and 24) reviewed for unnecessary medications. This placed residents at risk for adverse medication reactions and unnecessary medications. Findings include: 1. Resident 1 admitted to the facility in 4/2024 with diagnoses including depression. A review of Resident 1's pharmacy consultation reports revealed a 9/3/24 recommendation to attempt a gradual dose reduction on citalopram (an antidepressant medication). A review of Resident 1's medical record revealed no evidence of a signed physician order to attempt a gradual dose reduction on citalopram in 9/2024. A review of Resident 1's pharmacy consultation reports revealed a 10/1/24 recommendation to attempt a gradual dose reduction on citalopram. A review of Resident 1's medical record revealed a 10/8/24 order to decrease citalopram from 20 mg to 10 mg. On 12/4/24 at 1:47 PM Staff 8 (LPN Resident Care Manager) stated pharmacy recommendations should be addressed within a week of receiving the recommendations. Staff 8 confirmed Resident 1's pharmacy recommendation to attempt a gradual dose reduction on citalopram was not completed timely. 50897 2. Resident 24 admitted to the facility on [DATE] with diagnoses including heart disease. A pharmacist review completed 9/2024 instructed the facility to clarify Resident 24's order for carvedilol (a medication to treat hypertension) to administer the medication with food. A record review of Resident 24's MAR and physician orders completed 12/4/24 revealed Resident 24's orders were not updated with the instruction to administer her/his carvedilol with food. In an interview on 12/4/24 at 4:00 PM Staff 2 (DNS) acknowledged Resident 24's orders were not updated to reflect her/his carvedilol needed to be given with food.

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 47001 Based on interview and record review it was determined the facility failed to process physician laboratory orders timely for 2 of 5 sampled residents (#s 1 and 20) reviewed for unnecessary medications. This placed residents at risk for unnecessary medications. Findings include: 1. Resident 1 admitted to the facility in 4/2024 with diagnoses including depression. A review of Resident 1's orders revealed a 5/7/24 order for a comprehensive metabolic panel (laboratory test) to be completed on the next lab day and every six months. A review of Resident 1's laboratory test results revealed a comprehensive metabolic panel completed on 9/7/24. On 12/4/24 at 2:05 PM Staff 2 (DNS) acknowledged Resident 1's comprehensive metabolic panel was ordered on 5/7/24 but not completed until 9/7/24. Staff 2 stated the test was not completed timely. 2. Resident 20 admitted to the facility in 8/2024 with diagnoses including depression. A review of Resident 20's orders revealed an 8/9/24 order for a lipid panel (laboratory test) to be completed the next lab day and every 12 months. A review of Resident 20's laboratory test results revealed a lipid panel completed on 9/5/24. On 12/4/24 at 2:05 PM Staff 2 (DNS) acknowledged Resident 20's lipid panel was ordered on 8/9/24 but not completed until 9/5/24. Staff 2 stated the test was not completed timely.

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 47001 Based on interview and record review it was determined the facility failed to make a dental appointment for 1 of 2 sampled residents (#1) reviewed for dental needs. This placed residents at risk for unmet dental needs. Findings include: Resident 1 admitted to the facility in 4/2024 with diagnoses including depression. On 12/2/24 at 2:48 PM Resident 1 stated the facility informed her/him they were going to make a dental appointment for new dentures at her/his last care conference approximately two to three months ago, but no dental appointment was scheduled. On 12/4/24 at 2:19 PM Staff 8 (LPN Resident Care Manager) stated during the 10/17/24 Care Conference Resident 1 indicated she/he needed to see the dentist and Staff 8 stated the appointment was not scheduled. Staff 8 acknowledged Resident 1 did not have timely follow up for her/his dental appointment needs.