

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/08/2024
NAME OF PROVIDER OR SUPPLIER  Regency Albany		STREET ADDRESS, CITY, STATE, ZIP CODE  805 19th Avenue SE Albany, OR 97321	

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>42270</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were treated with respect and dignity for 1 of 3 sampled residents (#1) reviewed for dignity. This placed residents at risk for lack of dignity. Findings include:</p> <p>Resident 1 admitted to the facility in 1/2015 with diagnoses including cerebral palsy (a disorder that affects movement, muscle tone, and posture).</p> <p>A 1/22/24 Annual MDS revealed Resident 1 was able to understand others, was cognitively intact, had no behaviors, and was dependent on staff for toileting.</p> <p>A public complaint was received on 2/6/24 which alleged while providing toileting assistance to Resident 1 two caregivers made fun of her/him and how her/his feces smelled.</p> <p>A review of Resident 1's Progress Notes revealed no documentation of the alleged incident.</p> <p>On 11/4/24 at 10:49 AM Resident 1 stated an agency staff member made a comment about how her/his feces smelled. Resident 1 stated she/he notified Staff 21 (Activities Director), but she/he did not know what happened as a result of that report. Resident 1 stated nobody should experience comments made about their basic bodily functions.</p> <p>On 11/5/24 at 1:40 PM Staff 21 stated, when she was notified by Resident 1 she/he was embarrassed about the comment made by agency staff, she notified the administrator.</p> <p>On 11/6/24 at 3:55 PM Staff 1 (Administrator) stated she was aware of Resident 1's allegation and the facility terminated Staff 31's (Former Agency CNA) contract due to the comment made to Resident 1. Staff 1 stated the comment was inappropriate.</p> <p>On 11/7/24 at 8:44 AM Staff 1 provided an undated and untitled typed statement about the incident with Resident 1. The statement revealed Staff 1 was made aware of Resident 1's concern with Staff 31 on 2/2/24, Staff 31's contract was terminated early, and Resident 1 indicated it was difficult enough to not be able to take care of her/his self to have to depend on other people who are supposed to be caring for me take away more of my dignity.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/7/24 at 12:59 PM Staff 25 (CNA) stated she recalled the event. Staff 25 stated she was notified by Resident 1 after the incident occurred. Staff 25 stated Resident 1 reported she/he was shamed for having diarrhea. Staff 25 stated Resident 1 reported feeling embarrassed about the comment. Staff 25 stated other residents reported having issues with the staff involved and the CNA's contract ended early.</p> <p>On 11/8/24 at 8:40 AM Staff 1 reported Staff 31 did not treat Resident 1 with respect and dignity.</p> <p>On 11/8/24 at 12:26 PM Staff 31 (Former Agency CNA) denied she made any comments about Resident 1's feces.</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>Reasonably accommodate the needs and preferences of each resident.</p> <p>41455</p> <p>Based on observation, interview and record review it was determined the facility failed to assess for and provide an appropriate call light system of 1 of 1 sampled resident (#11) reviewed for hydration. This placed residents at risk for unmet needs and lack of ability to call for assistance. Findings include:</p> <p>Resident 11 admitted to the facility in 2/2020 with diagnoses including Parkinson's disease (progressive disease of the nervous system) and edema (fluid retention).</p> <p>A 11/4/24 revised care plan indicated:</p> <ul style="list-style-type: none"> <li>- Resident 11 had orders for a diuretic (medication used to assist the removal of extra fluid from the body), fluids were important to the resident, and to encouraged fluids of her/his choice.</li> <li>-Resident 11 had hand contractures and a push pad call light was to be within her/his reach and she/he required maximum assistance for eating.</li> </ul> <p>On 11/4/24 at 10:07 AM Resident 11 was observed in bed with her/his hands in a clinched position and she/he was unable to use her/his button call light.</p> <p>On 11/4/24 at 1:39 PM Resident 11 was observed in bed and unable to use her/his push pad call light. Resident 11 stated if she/he was able to use the push pad call light she/he would ask for something to drink because she/he was thirsty. Resident 11 indicated her/his push pad call light was new, but she/he continued to need to yell for assistance. Staff 36 (RA) entered the room and stated the care needs for Resident 11 continued to increase and staff occasionally offered her/him water.</p> <p>On 11/6/24 at 9:48 AM Staff 16 (CNA) confirmed Resident 11 was unable to use the new push pad call light, and her/his care plan had no reference to her/him calling out to obtain assistance or to offer her/him fluids frequently.</p> <p>On 11/6/24 at 12:13 PM Resident 11 stated she/he became frustrated when she/he saw staff in the hallway who did not respond when she yelled for assistance.</p> <p>On 11/7/24 at 11:42 AM Staff 11 (Resident Care Manager-LPN) acknowledged Resident 11 was not assessed prior to the implementation of the new push pad call light, and the resident's care plan required additional interventions to address her/his fluid and call light needs.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>34703</p> <p>Based on interview and record review it was determined the facility failed to obtain information related to advance directives and health care decisions for 4 of 5 sampled residents (#s 8, 20, 30 and 32) reviewed for advance directives. This placed residents at risk for not having their health care decisions honored. Findings include:</p> <p>1. Resident 8 admitted to the facility in 9/2024 with diagnoses including a leg fracture.</p> <p>A 9/30/24 Interdisciplinary Care Conference assessment revealed Resident 8 did not have an advance directive, but indicated there was an advance directive in the electronic record. Review of Resident 8's electronic record revealed no advance directive, and further indicated Resident 8 had a POLST (Physician Orders for Life-Sustaining Treatment) which was not signed by the physician.</p> <p>On 11/7/24 at 11:10 AM Staff 24 (Social Service Director) stated she reviewed advance directives at care conferences, and tried to make a note to indicate if an advance directive was provided or not wanted. Staff 24 stated she provided advance directive packets to residents at the care conferences, and if the resident requested assistance she provided it. Staff 24 stated she did not conduct follow up related to provided advance directives.</p> <p>2. Resident 30 admitted to the facility in 8/2024 with diagnoses including an open wound to the left leg.</p> <p>A 9/18/24 Interdisciplinary Care Conference assessment revealed Resident 30 did not have an advance directive, but an advance directive booklet would be provided for the resident and family to review. A review of Resident 30's Progress Notes from 8/27/24 through 10/5/24 revealed no documentation related to an advance directive.</p> <p>On 11/5/24 at 5:35 PM Staff 24 (Social Service Director) stated she reviewed advance directives in care conferences and tried to make a note to indicate if an advance directive was provided or not wanted. Staff 24 stated she provided advance directive packets to residents in the care conferences and if the resident requested assistance she provided it. Staff 24 stated she did not follow up on provided advance directives.</p> <p>3. Resident 32 admitted to the facility in 8/2024 with diagnoses including malnutrition.</p> <p>An 8/15/24 Interdisciplinary Care Conference assessment revealed Resident 32's son would bring her/his advance directive to the facility.</p> <p>An 9/15/24 Interdisciplinary Care Conference assessment revealed Resident 32 did not have an advance directive, but an advance directive booklet would be provided for the resident and family to review. A review of Resident 32's Progress Notes from 8/15/24 through 11/4/24 revealed no documentation related to an advance directive.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/5/24 at 5:35 PM Staff 24 (Social Service Director) stated she reviewed advance directives in care conferences and tried to make a note to indicate if an advance directive was provided or not wanted. Staff 24 stated she provided advance directive packets to residents in the care conferences and if the resident requested assistance she provided it. Staff 24 stated she did not follow up on provided advance directives.</p> <p>42270</p> <p>4. Resident 20 admitted to the facility in 10/2019 with diagnoses including diabetes.</p> <p>A 7/20/24 Quarterly MDS revealed Resident 20 had a BIMS score of 15 which indicated she/he was cognitively intact.</p> <p>A review of Resident 20's medical record revealed no advance directive.</p> <p>A 11/15/23 Interdisciplinary Care Conference assessment revealed Resident 20 did not have an advance directive and there was no indication if one was offered.</p> <p>A 2/7/24 Interdisciplinary Care Conference assessment revealed Resident 20 did not have an advance directive and a copy of an advance directive booklet was provided to Resident 20.</p> <p>A 5/8/24 Interdisciplinary Care Conference assessment revealed Resident 20 did not have an advance directive, there was no indication one was offered, and there was no follow up from the copy provided at the 2/7/24 Interdisciplinary Care Conference.</p> <p>A 7/31/24 Interdisciplinary Care Conference assessment revealed Resident 20 did not have an advance directive and there was no indication one was offered.</p> <p>A review of Resident 20's Progress Notes from 11/2023 through 11/5/24 revealed no documentation related to an advance directive.</p> <p>On 11/5/24 at 5:35 PM Staff 24 (Social Services Director) stated she reviewed advance directives in care conferences and tried to make a note to indicate if an advance directive was provided or not wanted. Staff 24 stated she provided advance directive packets to residents in the care conferences and if the resident requested assistance she provided it. Staff 24 stated she did not follow up on provided advance directives until the next quarterly care conference.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>42270</p> <p>Based on observation and interview the facility failed to provide a homelike dining environment for 3 of 3 dining rooms reviewed for dining. This placed residents at risk for living in an institutional environment. Findings include:</p> <p>On 11/4/24 at 11:58 AM, while four residents ate in the Middle dining room, their meals were observed left on the delivery tray during the meal.</p> <p>On 11/5/24 at 12:13 PM the Middle dining room was observed. Residents sat at three different tables, one of the tables had a plant, the other tables had no table decoration, and none of the tables had a tablecloth. Five residents ate in the room and all residents' plates were on left on the plate warmer and were left on trays.</p> <p>On 11/5/24 at 12:15 PM the Back dining room was observed. Three residents were at one table in the dining room, no tablecloth was present, and all resident meals were left on trays.</p> <p>On 11/5/24 at 12:18 PM the Front dining room as observed. Two residents were observed eating in the room and both of their meals were left on trays.</p> <p>On 11/5/24 at 12:22 PM Staff 1 (Administrator) stated the facility should make meals feel like home. Staff 1 stated the expectation was for staff to remove the tray and plate warmer unless the resident requested either to remain, and staff were to make it feel like home.</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47001</p> <p>Based on interview and record review it was determined the facility failed to protect residents from verbal abuse by staff for 2 of 2 sampled residents (#s 1 and 18) reviewed for abuse. Resident 18 experienced psychosocial harm. Findings include:</p> <p>1. Resident 18 admitted to the facility in 2/2022 with diagnoses including anxiety and depression.</p> <p>A 7/28/24 Quarterly MDS revealed Resident 18 was cognitively intact.</p> <p>On 9/3/24 a FRI was received which alleged on 8/31/24 Staff 38 (Former Agency CNA) assisted Resident 18 onto the bed pan. When Resident 18 was finished Staff 38 attempted to assist Resident 18 off the bedpan. Resident 18 was unable to assist with bed mobility and asked Staff 38 to get assistance, but Staff 38 refused. Staff 38 was able to get Resident 18 off the bedpan, but the bedpan spilled onto Resident 18's bed. Resident 18 repeated her/his request for Staff 38 to get assistance. Staff 38 refused to get assistance and proceeded to clean Resident 18 while making comments about the mess in the bed and telling Resident 18 to roll over further. Resident 18 continued to express to Staff 38 she/he was unable to move further without additional assistance. Resident 18 stated she/he felt like Staff 38 stripped [her/him] of [her/his] last ounce of dignity.</p> <p>A 1/28/23 Care Plan revealed Resident 18 was care planned for two-person extensive assistance with bed mobility.</p> <p>On 11/7/24 at 11:07 AM Staff 2 (DNS) stated he was notified of an allegation of abuse involving Staff 38 right after the incident occurred on 8/31/24, and Staff 38 was sent home immediately. Staff 2 stated Resident 18 expressed feeling safe since Staff 38 was sent home. Staff 2 stated the incident was abusive, but Resident 18 was not harmed. Staff 2 acknowledged Resident 18 was not placed on alert for psychosocial harm.</p> <p>On 11/7/24 at 11:24 AM Staff 9 (Regional Nurse) stated it was expected for residents to be placed on alert after an allegation of abuse to monitor for any physical or psychosocial harm.</p> <p>On 11/8/24 at 8:03 AM Resident 18 stated the incident on 8/31/24 with Staff 38 made her/him .feel horrible; less than human. Resident 18 stated she/he still felt .like a piece of meat and to this day [she/he felt] less than a person.</p> <p>On 11/8/24 at 8:27 AM Staff 1 (Administrator) acknowledged the facility failed to place Resident 18 on alert to monitor for any psychosocial harm after the incident on 8/21/24. Staff 1 stated Resident 18 was not harmed, but she/he was stripped of her/his dignity, which is why Staff 38 was removed from the facility.</p> <p>42270</p> <p>2. Resident 1 admitted to the facility in 1/2015 with diagnoses including cerebral palsy (a disorder that affects movement, muscle tone, and posture).</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>A 1/22/24 Annual MDS revealed Resident 1 had a BIMS score of 15 which indicated she/he was cognitively intact.</p> <p>A 5/13/24 Grievance form revealed Resident 1 approached Staff 22 (Kitchen Manager) on 5/13/24 after Food Committee to discuss a concern with a previous meal she/he felt caused diarrhea. The grievance revealed Staff 22 became defensive, raised his voice to Resident 1, and said he was not going to let her/him say it was food poisoning. Resident 18, Resident 27, and Staff 21 (Activities Director) were also present in the room. Resident 18 told Staff 22 he should not speak to Resident 1 like that. Resident 27 said he should not raise his voice and condescend Resident 1.</p> <p>A 5/20/24 Resident Council Meeting Notes included the following hand-written statement: We as residents don't feel safe, secure, and safe from all types of abuse, and that is not being addressed. We feel that we can be yelled at in front of a few people. Lots of people thought he [Staff 22] should have been fired on the spot. [Staff 22] thinks [Staff 22] can do whatever he wants to whats next.</p> <p>A 5/20/24 Alleged Abuse Investigation revealed the incident with Resident 1 and Staff 22 was brought up at the 5/20/24 Resident Council and then investigated as abuse. Resident 27 did not feel it was abusive initially, but with further discussion she/he felt the incident was verbal abuse and brought it up in Resident Council. Staff 21 stated Staff 22 spoke to Resident 1 in an elevated tone, but it was not considered abuse. Resident 18 stated she/he told Staff 22 to stop being so rude and she/he felt the interaction could be considered abuse. Resident 1 stated Staff 22 .was not receptive to what [she/he] was saying and began yelling at [her/him]. [Staff 22] would not listen to what [she/he] was saying. [Staff 22] continued to yell and finally just walked away.</p> <p>On 11/4/24 at 10:45 AM Resident 1 stated she/he spoke to Staff 22 about the possibility a meal caused diarrhea. Resident 1 stated Staff 22 got two inches from her/his face and stated Prove it; provide it. multiple times to her/him. Resident 1 stated she/he was taken aback by the entire incident, she/he felt the event would be considered verbal abuse, and it made her/him feel uncomfortable about it. Resident 1 stated Staff 22 got in her/his face for no reason.</p> <p>On 11/6/24 at 11:05 AM Resident 27 stated she/he was present for the incident between Resident 1 and Staff 22 on 5/13/24. Resident 27 stated Staff 22 yelled and it made her/him jump. Resident 27 stated Staff 22 yelled at the top of his lungs, and every time Resident 1 mentioned fish Staff 22 would say Prove it. Resident 27 stated she/he was appalled, the residents were all bothered that Staff 22 was still at the facility, and she/he definitely felt it was verbal abuse.</p> <p>On 11/6/24 at 11:14 AM Resident 18 stated she/he was present for the incident on 5/13/24, she/he recalled Resident 1 spoke about food, and Staff 22 blew up without any warning and yelled statements repeatedly. Resident 18 stated she/he told Staff 22 he was being inappropriate, and she/he characterized the incident as verbal abuse and Resident 1 was upset afterward. Resident 18 stated Staff 22 tended to raise his voice with residents and it was not appropriate.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/6/24 at 12:25 PM Staff 21 stated she was present for the incident between Resident 1 and Staff 22 on 5/13/24. Staff 21 stated Resident 1 waited until after everyone left the Food Committee meeting and told Staff 22 a fish meal was undercooked. Staff 21 stated Staff 22 basically attacked Resident 1 with accusations and stated there was no way Resident 1 could know if the fish was undercooked. Staff 21 stated anytime Resident 1 tried to speak Staff 22 interrupted her/him and absolutely raised his voice. Staff 21 stated she got between Resident 1 and Staff 22 and attempted to intervene. Staff 21 stated Staff 1 (Administrator) was notified immediately and she felt the interaction was verbal abuse.</p> <p>On 11/6/24 at 1:08 PM Staff 22 stated Resident 1 brought up an issue about residents getting sick from seafood. Staff 22 stated he did not yell at Resident 1, and he was notified when he stood above a resident in a wheelchair his voice could carry and it was about perception.</p> <p>On 11/8/24 at 8:40 AM Staff 1 stated Staff 22 did not respond appropriately to Resident 1, and was unprofessional and defensive. Staff 1 stated at the time there was no indication of verbal abuse, but at the next Resident Council meeting there was a written statement generated regarding abuse after which she immediately started an abuse investigation. Staff 1 stated abuse was ruled out in the investigation, however she confirmed staff raised their voice, talked over a resident, and this could be considered verbal abuse.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47001</p> <p>Based on interview and record review it was determined the facility failed to timely report to the State Survey Agency (SSA) an allegation of abuse for 1 of 2 sampled residents (#18) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>Resident 18 admitted to the facility in 2/2022 with diagnoses including anxiety and depression.</p> <p>On 9/3/24 a FRI was received by the SSA reporting an 8/31/24 allegation of abuse.</p> <p>On 11/7/24 at 11:23 AM Staff 1 (Administrator) stated she was unable to recall when the FRI was sent to the SSA.</p> <p>On 11/27/24 at 11:23 AM Staff 2 (DNS) stated the incident occurred on 8/31/24, which was a Saturday, and Monday 9/2/24 was a holiday, so the FRI was sent to the SSA on Tuesday 9/3/24.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>47001</p> <p>Based on interview and record review it was determined the facility failed to accurately assess 1 of 5 sampled residents (#25) reviewed for discharge. This placed residents at risk for unmet and unidentified needs. Findings include:</p> <p>Resident 25 admitted to the facility in 9/2020 with diagnoses including bipolar disorder.</p> <p>A 9/28/24 Annual MDS indicated Resident 25 did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. Resident 25 did not want to be asked about returning to the community on all assessments.</p> <p>On 11/4/24 at 10:35 AM Resident 25 stated he wanted to discharge to a home in Corvallis.</p> <p>On 11/5/24 at 1:02 PM Resident 25 stated he wanted to discharge to a home in Corvallis.</p> <p>On 11/6/24 at 11:00 AM Resident 25 stated he wanted to discharge from the facility to either Corvallis or Philomath.</p> <p>On 11/6/24 at 1:37 PM Staff 24 (Social Service Manager) stated Resident 25 wanted to discharge to a home in Corvallis or Philomath. Staff 25 stated the facility was working with Resident 25's case worker to find her/him placement outside the facility.</p> <p>On 11/8/24 at 10:16 AM Staff 37 (Social Service Assistant) stated Resident 25 wanted to go home and the information on the 9/28/24 Annual MDS was incorrect.</p> <p>On 11/8/24 at 11:59 AM Staff 9 (Regional Nurse) acknowledged the 9/28/24 Annual MDS was incorrect, and the facility was making corrections to the MDS.</p>		

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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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>47001</p> <p>Based on interview and record review it was determined the facility failed to ensure residents identified with serious mental illness were evaluated and received care and services to meet their needs for 1 of 1 sampled resident (#25) reviewed for PASRR. This placed residents at risk for unassessed and unmet mental health needs. Findings include:</p> <p>Resident 25 admitted to the facility in 9/2020 with diagnoses including bipolar disorder.</p> <p>A 9/17/24 PASRR Level 1 form indicated Resident 25 had serious mental illness indicators and required further evaluation at the nursing facility.</p> <p>On 11/6/24 at 1:37 PM Staff 24 (Social Service Manager) acknowledged the PASRR Level 1 form indicated Resident 25 had serious mental illness indicators and required further evaluation at the nursing facility, but Resident 25 did not have further evaluations completed for mental illness.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/08/2024
NAME OF PROVIDER OR SUPPLIER  Regency Albany		STREET ADDRESS, CITY, STATE, ZIP CODE  805 19th Avenue SE Albany, OR 97321	
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>34703</p> <p>Based on observation, interview and record review it was determined facility staff failed to follow professional standards of practice for medication administration and wound care for 4 of 7 sampled residents (#s 9, 10, 19, and 33) reviewed medication administration and wound care. This placed residents at risk for unsafe medication administration and cross contamination. Findings include:</p> <p>1. Resident 9 admitted to the facility in 2/2017 with diagnoses including heart disease.</p> <p>An 10/1/24 physician order indicated Resident 9 received Cephalexin (antibiotic) BID.</p> <p>An 10/16/24 physician order indicated Resident 9 received Losartan (for high blood pressure) BID.</p> <p>The 11/2024 MAR indicated Resident 9 was to receive her/his medication at 8:00 AM.</p> <p>The facility's standing orders indicated blood pressure parameters included to hold all blood pressure medications for systolic (pressure in your blood vessels when your heart contracts) blood pressure less than 100.</p> <p>On 11/7/24 at 9:45 AM Staff 28 (LPN) administered Resident 9's Losartan at 9:45 AM, one hour and 45 minutes late, but did not check her/his blood pressure prior to administering the medication.</p> <p>On 11/7/24 at 9:50 AM Staff 28 stated when she was running late administering medications she just kept going to hopefully catch-up. Staff 28 stated she spoke with management regarding what the process was when staff are running late passing medications, but did not receive feedback. Staff 28 acknowledged she did not check Resident 9's blood pressure before administering her/his Losartan.</p> <p>2. Resident 10 admitted to the facility in 7/2024 with a Stage 4 (severe damage to the skin, and the surrounding tissue begins to die) pressure ulcer.</p> <p>The 7/22/24 Admission MDS indicated Resident 10 was at high risk for developing another pressure ulcer due to malnutrition, incontinence, functional impairment and cognitive loss. Resident 10 was unable to execute major repositioning independently and relied on staff for assistance. The wound nurse provided wound care to Resident 10's pressure ulcer including measurements, assessment of the wound bed weekly with adjustment to the wound care orders as needed.</p> <p>On 11/6/24 at 9:45 AM Staff 11 (Resident Care Manager-LPN) was observed to perform wound care for Resident 10. During the dressing change the following was observed;</p> <p>-Staff 11 donned a gown and gloves without sanitizing her hands.</p> <p>-Staff 11 placed all clean dressing supplies including bandage scissors on Resident 10's bedside table which had incontinent pads and a urinal on top of the table. Staff began touching drawers of the resident's nightstand to obtain more supplies and did not change her gloves.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Staff 11 then moved the clean supplies to Resident 10's bed on her/his incontinent pad and did not prepare a clean surface.</p> <p>-Staff 11 removed the resident's incontinent brief, removed the wound dressing, and cleansed the wound with her/his soiled gloves. Staff 11 proceeded to open the wound dressing packages with the same gloves, cut the new dressing with the soiled scissors and place the new dressings in the wound with the soiled gloves. Staff 11 used her fingers with donned with the soiled gloves instead of a clean Q-tip to place the dressing inside the wound.</p> <p>-Staff 11 proceeded to open another dressing package, cover the wound, reach into her pocket and obtain a permanent marker, write on the bandage, then place the pen back in her pocket.</p> <p>On 11/6/24 at 10:10 AM Staff 11 acknowledged she did not set-up a clean field for dressing supplies and did not change her gloves and sanitize her hands like she should have.</p> <p>On 11/6/24 at 10:30 AM Staff 9 (Regional Nurse) stated Staff 11 recently finished a wound class and should know to provide a clean area for dressings, change gloves and sanitize hands often when touching dirty dressings and applying clean dressings.</p> <p>3. Resident 19 admitted to the facility in 2/2022 with diagnoses including respiratory failure.</p> <p>A random observation on 11/8/24 at 8:35 AM revealed Staff 30 (LPN) reached into a resident's medication cup with multiple medications in the cup without sanitizing her hands or donning gloves, obtained a medication capsule from the cup, pulled the capsule apart, and placed the contents of the capsule in pudding.</p> <p>On 11/8/24 at 8:29 AM Staff 30 acknowledged she did not sanitize her hands or don gloves before she touched the resident's medications.</p> <p>b. A 2/21/22 physician order indicated Resident 19 received Combivent inhaler (for wheezing and shortness of breath) four times a day, and was to rinse her/his mouth after each use.</p> <p>On 11/8/24 at 8:35 AM Staff 30 administered the Combivent inhaler, but did not have Resident 19 rinse her/his mouth.</p> <p>On 11/8/24 at 8:40 AM Staff 30 stated she did not have the resident rinse her/his mouth after she/he received her/his inhaler per the physician order because she forgot and took the resident's water away. Staff 30 did not go back into the resident's room to have her/him rinse her/his mouth.</p> <p>c. A 2/22/24 physician order indicated Resident 19 received Metoprolol ER (extended release for high blood pressure) every morning.</p> <p>The facility's standing orders indicated blood pressure parameters included to hold all blood pressure medications for systolic (pressure in your blood vessels when your heart contracts) blood pressure less than 100.</p> <p>Staff 30 was observed asking CNAs for a blood pressure level for Resident 19 which were obtained at 6:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/8/24 at 9:37 AM Staff 1 (Administrator) and Staff 9 (Regional Nurse) confirmed touching a resident's medication with bare unsanitary fingers by the staff was unacceptable. Staff 9 stated Staff 30 should not ask CNAs for a blood pressure level obtained hours before administering a medication requiring a blood pressure level check, rather she should have obtained the resident's blood pressure level right before administering Metoprolol.</p> <p>4. Resident 33 admitted to the facility in 10/2024 with diagnoses including heart disease and thyroid disorder.</p> <p>An 10/4/24 physician order indicated Resident 33 received Apixiban (blood thinner), Carvedilol (for high blood pressure), and Levothyroxine (thyroid medication).</p> <p>An 10/15/24 physician order indicated Resident 33 received Losartan (for high blood pressure).</p> <p>The 11/2024 MAR indicated Resident 33 received her/his medications at 8:00 AM.</p> <p>On 11/7/24 at 9:30 AM Staff 14 (LPN) administered Resident 33's medications, which was one hour and 30 minutes late, and was after Resident 33 consumed her/his breakfast meal.</p> <p>The facility's standing orders indicated blood pressure parameters included to hold all blood pressure medications for systolic (pressure in your blood vessels when your heart contracts) blood pressure less than 100. Staff 14 did not perform a blood pressure check before administering Resident 33's blood pressure medications.</p> <p>Per Drugs.com Levothyroxine should be taken in the morning on an empty stomach, at least 30 to 60 minutes before eating breakfast.</p> <p>On 11/7/24 at 9:40 AM Staff 14 stated he was not told what to do when he was running late administering medications. Staff 14 acknowledged he did not check Resident 33's blood pressure level prior to administering Resident 33's Losartan and Carvedilol.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>47001</p> <p>Based on interview and record review it was determined the facility failed to provide activities of choice for 1 of 2 residents (#18) reviewed for activities. This placed residents at risk for diminished quality of life. Findings include:</p> <p>Resident 18 admitted to the facility in 2/2022 with diagnoses including anxiety and depression.</p> <p>A 7/28/24 Quarterly MDS revealed Resident 18 was cognitively intact.</p> <p>On 11/4/24 at 11:00 AM Resident 18 stated she/he did not participate in Catholic communion since the beginning of 2024.</p> <p>A 11/2024 Activities Calendar revealed Catholic communion was scheduled for 11/5/24.</p> <p>On 11/7/24 at 9:22 AM Resident 18 stated she/he did not receive communion on 11/5/24.</p> <p>Spiritual activity participation documentation from 8/2/24 through 11/6/24 revealed Resident 18 participated in a spiritual activity once on 9/12/24.</p> <p>On 11/7/24 at 9:31 AM Staff 21 (Activity Director) stated no one was able to come in on 11/5/24 for communion due to the facility COVID outbreak. Staff 21 stated she was not documenting when residents received communion.</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>41455</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders for insulin administration for 1 of 5 residents (#15) reviewed for medications. This placed residents at risk for unstable blood sugars. Findings include:</p> <p>Resident 15 admitted to the facility in 11/2021 with diagnoses including diabetes and depression.</p> <p>An 10/24/24 signed physician order revealed Resident 15 had orders for 13 units of Humalog (short acting insulin) before each meal, and to hold the medication if her/his CBG level was less than 100.</p> <p>The 11/2024 Licensed Nurse Administration Record indicated the following:</p> <ul style="list-style-type: none"> <li>-On 11/1/24 at 12:00 PM Resident 15's CBG level was 123 and Humalog was held by Staff 13 (LPN)</li> <li>-On 11/6/24 at 12:00 PM Resident 15's CBG level was 110 and Humalog was held by Staff 13.</li> </ul> <p>On 11/8/24 at 8:46 AM Staff 13 stated she believed the facility had standing orders to hold insulin if a resident's CBG level was at 150 or above. Staff 13 stated she did not contact Resident 15's physician for clarification of the resident's Humalog order.</p> <p>On 11/8/24 at 10:52 AM Staff 9 (Regional Nurse) acknowledged physician orders for Resident 15 should be followed as written.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>34703</p> <p>Based on observation, interview and record review it was determined the facility failed to properly assess and treat pressure ulcers for 2 of 2 sampled residents (#s 8 and 10) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include:</p> <p>1. Resident 8 admitted to the facility in 9/2024 with diagnoses including a leg fracture.</p> <p>The 9/26/24 care plan indicated Resident 8 had current skin concerns including blisters to her/his left thigh caused by a leg brace.</p> <p>The 9/29/24 New Skin Issue Incident Report indicated Staff 13 (LPN) was notified of blisters to Resident 8's inner thigh underneath her/his buttocks.</p> <p>The 9/30/24 Initial Non-Pressure Skin Evaluation indicated Resident 8 had a blister to the rear aspect of the left thigh related to leg immobilizer use. Instructions indicated to cover blisters to protect the skin and prevent further skin injury.</p> <p>Staff 2 (DNS) indicated Resident 8 developed blisters, the wound nurse assessed the situation and implemented a plan of correction to prevent recurrence.</p> <p>The report did not include interviews from the CNA who identified the skin condition or the resident.</p> <p>CDC pressure ulcer guidelines indicated a blister represents a disruption in the skin's integrity and is considered a Stage 2 pressure ulcer.</p> <p>On 11/6/24 at 10:41 AM Staff 11 (Resident Care Manager-LPN) stated she assessed the blisters and placed a foam dressing to prevent further blisters. Staff 11 acknowledged the blisters should be documented as a Stage 2 pressure ulcer not blisters. Staff 11 acknowledged the Incident Report was not accurate or thorough.</p> <p>2. Resident 10 admitted to the facility in 7/2024 with a Stage 4 (severe damage to the skin, and the surrounding tissue begins to die) pressure ulcer.</p> <p>The 7/22/24 Admission MDS indicated Resident 10 was at high risk for developing another pressure ulcer due to malnutrition, incontinence, functional impairment and cognitive loss. Resident 10 was unable to execute major repositioning independently and relied on staff for assistance. The wound nurse provided wound care to Resident 10's pressure ulcer including measurements, assessment of the wound bed weekly with adjustment to the wound care orders as needed.</p> <p>On 11/6/24 at 9:45 AM Staff 11 (Resident Care Manager-LPN) was observed to perform wound care for Resident 10. During the dressing change the following was observed;</p> <p>-Staff 11 donned a gown and gloves without sanitizing her hands.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff 11 placed all clean dressing supplies including bandage scissors on Resident 10's bedside table which had incontinent pads and a urinal on top of the table. Staff began touching drawers of the resident's nightstand to obtain more supplies and did not change her gloves.</p> <p>-Staff 11 then moved the clean supplies to Resident 10's bed on her/his incontinent pad and did not prepare a clean surface.</p> <p>-Staff 11 removed the resident's incontinent brief, removed the wound dressing, and cleansed the wound with her/his soiled gloves. Staff 11 proceeded to open the wound dressing packages with the same gloves, cut the new dressing with the soiled scissors and place the new dressings in the wound with the soiled gloves. Staff 11 used her fingers with donned with the soiled gloves instead of a clean Q-tip to place the dressing inside the wound.</p> <p>-Staff 11 proceeded to open another dressing package, cover the wound, reach into her pocket and obtain a permanent marker, write on the bandage, then place the pen back in her pocket.</p> <p>On 11/6/24 at 10:10 AM Staff 11 acknowledged she did not set-up a clean field for dressing supplies and did not change her gloves and sanitize her hands like she should have.</p> <p>On 11/6/24 at 10:30 AM Staff 9 (Regional Nurse) stated Staff 11 recently finished a wound class and should know to provide a clean area for dressings, change gloves and sanitize hands often when touching dirty dressings and applying clean dressings.</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> 41455</p> <p>Based on observation, interview, and record review the facility failed to ensure the environment was free from accident hazards for 2 of 2 sampled resident (#s 17 and 37) reviewed for accidents. This placed residents at risk for injury. Findings include:</p> <p>1. Resident 17 admitted to the facility in 2/2024 with diagnoses including depression and severe obesity.</p> <p>A 9/23/24 revised care plan revealed Resident 17 exhibited personal property hoarding behaviors and to notify Staff 1 (Administration) if problems arose.</p> <p>An 10/27/24 Progress Note indicated Resident 17's table fell on her/his left shin, a small abrasion was noted and orders were entered to monitor and care for the wound.</p> <p>An 10/28/24 New Non-Pressure Injury investigation by Staff 2 (DNS) revealed there were no predisposing environmental or situation factors found related to the abrasion to Resident 17's left shin.</p> <p>On 11/4/24 at 12:04 PM Resident 17 was observed in bed with cardboard boxes around the perimeter of her/his room, and various items were on her/his bedside table with little room for her/his meal. Resident 17 stated her/his bedside table fell on her/his leg last week and the same table was in use without any evaluation of the table.</p> <p>On 11/6/24 at 4:37 PM Staff 9 (Regional Nurse) indicated the 10/28/24 New Non-Pressure Injury investigation was incomplete for an accident.</p> <p>On 11/7/24 at approximately 8:30 AM an 10/28/24 Equipment Related or Involved investigation was provided by the facility. The investigation revealed on 11/5/24 Resident 17's bedside table was evaluated and not broken.</p> <p>On 11/7/24 at 10:36 AM Staff 20 (Regional Nurse) acknowledged Resident 17's hoarding was not addressed until 11/7/24 and the investigation was not completed timely to prevent further injuries.</p> <p>50897</p> <p>2. Resident 37 admitted to the facility on [DATE] with diagnoses including chronic heart failure and dementia.</p> <p>An 8/15/24 care plan indicated fall mats were required on both sides of Resident 37's bed.</p> <p>Observations between 11/4/24 and 11/8/24 revealed no fall mats were in place on either side of Resident 37's bed.</p> <p>In an interview on 11/8/24 Staff 11 (Resident Care Manager-LPN) stated she did not know why there were no fall mats by Resident 37's bed and resident's care plan called for fall mats to be in place.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>34703</p> <p>Based on interview and record review it was determined the facility failed to provide care and services related to catheterization for 1 of 1 resident (#32) reviewed for catheterization. This placed residents at risk for a delay in treatment for UTIs. Findings include:</p> <p>Resident 32 admitted to the facility with diagnoses including a Stage 4 (large, deep wound) pressure ulcer.</p> <p>On 11/4/24 at 11:22 AM Resident 32's catheter was observed with blood in the tubing. Resident 32 stated blood in the catheter tubing was normal after a catheter was changed.</p> <p>Review of the 11/2024 TAR and Nursing Progress Noted revealed no documentation related to flushing the catheter, cleaning the catheter or changing the catheter.</p> <p>On 11/6/24 at 10:39 AM Staff 11 (Resident Care Manager-LPN) stated there was no documentation in Resident 32's electronic record that catheter care was provided to the resident</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>41455</p> <p>Based on observation, interview and record review it was determined the facility failed to provide respiratory care and services for 2 of 2 sampled residents (#s 17 and 28) reviewed for respiratory services. This placed residents at risk for respiratory infections. Findings include:</p> <p>1. Resident 17 admitted to the facility in 2/2024 with diagnoses including depression and sleep apnea (breathing which starts and stops during sleep).</p> <p>An 10/2017 Resident Equipment Sanitation policy indicated the nursing facility was to prevent the spread of potentially infectious agents through the use of appropriate and accepted sanitation procedures. The policy had no indication for the appropriate storage of respiratory equipment.</p> <p>The 3/1/24 Admission MDS indicated Resident 17 used a CPAP (Continuous Positive Airway Pressure) machine.</p> <p>A 5/7/24 physician order indicated to clean the CPAP mask, filter, tubing and machine every Tuesday on day shift.</p> <p>An 8/23/24 revised respiratory care plan indicated to ensure Resident 17's CPAP mask was clean and distilled/sterile water used in the machine, and to monitor for any respiratory infection.</p> <p>On 11/4/24 at 11:46 AM Resident 17's CPAP mask was not in use and observed on her/his counter with a used tissue by the mask. Resident 17 indicated she/he recently recovered from a sinus infection.</p> <p>On 11/5/24 at 12:32 PM Staff 17 (NA) stated she stored residents' CPAP equipment uncovered and in a drawer with other personal items.</p> <p>On 11/5/24 at 12:34 PM Staff 4 (Regional [NAME] President) acknowledged the corporate policy to maintain and store respiratory equipment was too vague and the facility relied on physician orders to ensure proper care was in place for a resident's CPAP equipment.</p> <p>On 11/5/24 at 1:07 PM Staff 2 (DNS) acknowledged Resident 17's CPAP mask was improperly stored and should be in a clean plastic bag when not in use.</p> <p>34703</p> <p>2. Resident 28 admitted to the facility in 8/2024 with diagnoses including respiratory failure.</p> <p>The 8/2/24 care plan revealed Resident 28 had an alteration in respiratory status related to sleep apnea (a serious sleep disorder which breathing repeatedly stops and starts), and used a BiPAP machine (a machine to help push air into the lungs).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Multiple random observations from 11/5/24 through 11/8/24 on day and evening shifts revealed Resident 28's BiPAP machine was on top of the nightstand, hanging over the nightstand, and hanging on the resident's bedrail in an unsanitary manner.</p> <p>On 11/5/24 at 1:07 PM Staff 2 (DNS) confirmed Resident 28's BiPAP mask was not stored in a sanitary manner and should be stored in a bag.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>34703</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure a medication error rate of less than five percent. There were seven errors out of 37 medication administration opportunities resulting in an 18.92 percent error rate. This placed residents at risk for an ineffective and unsafe medication regimen and risk of administering a BID medication to soon from the first dose Findings include:</p> <ol style="list-style-type: none"> <li>Resident 9 admitted to the facility in 2/2017 with diagnoses including heart disease.</li> </ol> <p>An 10/1/24 physician order indicated Resident 9 received Cephalexin (antibiotic) BID.</p> <p>An 10/16/24 physician order indicated Resident 9 received Losartan (for high blood pressure) BID.</p> <p>The 11/2024 MAR indicated Resident 9 received her/his medications at 8:00 AM.</p> <p>On 11/7/24 at 9:45 AM Staff 28 (LPN) administered Resident 9's medications at 9:45 AM, one hour and 45 minutes late.</p> <p>The facility's standing orders indicated blood pressure parameters included to hold all blood pressure medications for systolic (pressure in your blood vessels when your heart contracts) blood pressure less than 100. Staff 28 did not perform a blood pressure check before administering blood pressure medications.</p> <p>On 11/7/24 at 9:50 AM Staff 28 stated when she was running late administering medications she just kept going to hopefully catch up. Staff 28 stated she spoke with management regarding the procedure if she was running late passing medications, but did not receive feedback.</p> <p>On 11/7/24 at 2:13 PM Staff 9 (Regional Nurse) stated staff should notify management if they are running late administering medications.</p> <ol style="list-style-type: none"> <li>Resident 19 admitted to the facility in 2/2022 with diagnoses including respiratory failure. <ol style="list-style-type: none"> <li>A random observation on 11/8/24 at 8:24 AM revealed Staff 30 (LPN) reached into a resident's medication cup with multiple medications in the cup without sanitizing her hands or donning gloves, obtained a medication capsule from the cup, pulled the capsule apart, and placed the contents of the capsule in pudding.</li> </ol> <p>On 11/8/24 at 8:29 AM Staff 30 acknowledged she did not sanitize her hands or don gloves before she touched the resident's medications.</p> <ol style="list-style-type: none"> <li>A 2/21/22 physician order indicated Resident 19 received Combivent inhaler (for wheezing and shortness of breath) four times a day, and was to rinse her/his mouth after each use.</li> </ol> <p>On 11/8/24 at 8:35 AM Staff 30 administered the Combivent inhaler, but did not have Resident 19 rinse her/his mouth.</p> <p>(continued on next page)</p> </li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  Regency Albany		STREET ADDRESS, CITY, STATE, ZIP CODE  805 19th Avenue SE Albany, OR 97321	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/8/24 at 8:40 AM Staff 30 stated she did not have the resident rinse out her/his mouth after she/he received her/his inhaler per the physician order.</p> <p>On 11/8/24 at 9:37 AM Staff 1 (Administrator) and Staff 9 (Regional Nurse) stated Staff 30 should have donned gloves if she had to touch a resident's medication.</p> <p>3. Resident 33 admitted to the facility in 10/2024 with diagnoses including heart disease and thyroid disorder.</p> <p>An 10/4/24 physician order indicated Resident 33 received Apixiban (blood thinner), Carvedilol (for high blood pressure), and Levothyroxine (thyroid medication).</p> <p>An 10/15/24 physician order indicated Resident 33 received Losartan (for high blood pressure.)</p> <p>The 11/2024 MAR indicated Resident 33 was to receive her/his medications at 8:00 AM.</p> <p>On 11/7/24 at 9:30 AM Staff 14 (LPN) administered Resident 33's medications, one hour and 30 minutes late, which was after Resident 33 consumed her/his breakfast meal.</p> <p>The facility's standing orders indicated blood pressure parameters included to hold all blood pressure medications for systolic (pressure in your blood vessels when your heart contracts) blood pressure less than 100. Staff 14 did not perform a blood pressure check before administering Resident 33's blood pressure medications.</p> <p>Per Drugs.com Levothyroxine should be taken in the morning on an empty stomach, at least 30 to 60 minutes before eating breakfast.</p> <p>On 11/7/24 at 9:40 AM Staff 14 stated he was not told what to do when he was running late administering medications. Staff 14 acknowledged he did not check Resident 33's blood pressure level prior to administering Resident 33's Losartan and Carvedilol.</p> <p>On 11/7/24 at 2:13 PM Staff 9 (Regional Nurse) stated staff should notify management if they are running late administering medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34703</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure transmission based precautions were implemented, to properly sanitize resident care equipment and provide wound care in a sanitary manner for 6 of 6 sampled residents (#s 10, 19, 20, 27, 30 and 195) reviewed for clostridium difficile colitis (C-Diff, a bacterium that causes an infection of the colon with symptoms including: inflammation of the colon, diarrhea, and life-threatening damage to the colon), wound care and medication administration. This deficient practice was determined to be an immediate jeopardy (IJ) situation. Resident 30 admitted to the facility with C-Diff, but the facility failed to protect this and other residents and timely implement appropriate contact precautions and properly sanitize once the resident was deemed clear of C-Diff. Findings include:</p> <p>The online reference CDC Preventing C-Diff. revealed the best way to prevent the spread of C-Diff from person to person was for all healthcare workers to wash their hands with soap and water before and after caring for the resident.</p> <p>On 11/5/24 at 4:42 PM the facility administrative staff, including Staff 1 (Administrator), Staff 2 (DNS), Staff 4 (Regional [NAME] President), and Staff 9 (Regional Nurse) were notified of the IJ situation and were provided a copy of the IJ Template related to the facility's failure to ensure transmission-based precautions were implemented timely for Resident 30 related to C-Diff.</p> <p>On 11/6/24 at 12:38 PM an acceptable plan to remove the IJ situation was submitted by the facility. The plan indicated the facility would implement the following actions:</p> <ul style="list-style-type: none"> <li>-The hydration cart and vital sign equipment was sanitized to prevent the spread of infection.</li> <li>-Current staff on shift were re-educated on transmission-based precautions relative to C-Diff per the CDC guidelines prior to their next scheduled shift. Soap and water were reinforced as the standard for hand hygiene. Additional education was provided to include donning and doffing of PPE.</li> <li>-Nurse management would complete ongoing Infection Control rounds on all three shifts for the next 72 hours, and then conduct random audits on all three shifts for the next 30 days.</li> <li>-New admissions to the facility would be reviewed by the Regional Nurse and IP for the next 30 days to ensure that appropriate Infection Control measures were implemented, and Kardex and Care plans updated.</li> <li>-Resident 30 had completed her/his course of antibiotics and stools were formed. Resident 30 met the CDC criteria and precautions were removed. As of 11/6/24 she/he had her/his room deep-cleaned as well as linens changed. Resident 30 declined a shower but accepted a full bed bath.</li> <li>-Facility staff would be trained on providing hydration while facility residents were on transmission-based precautions including direction to obtain new water pitchers with each hydration pass.</li> <li>-Current residents on transmission-based precautions had donning and doffing procedures added to the signage on the residents' doors for easy staff reference.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Residents on transmission-based precautions were provided individual vital sign equipment while on transmission-based precautions.</p> <p>-The facility IP would complete further training presented by Oregon Care partners on transmission-based precautions no later than end of day on 11/7/24.</p> <p>-Facility equipment for those on transmission-based precautions would be sanitized utilizing the Clorox Bleach Germicidal wipes with a contact time of three minutes. Education was provided to facility staff on cleansing techniques.</p> <p>-The Regional Nurse would review the Infection Control portal three times per week for the next 30 days to ensure that infections were care planned and appropriate precautions were implemented.</p> <p>-A root cause analysis would be completed by the Governing Body and brought to the facility QAPI committee for review.</p> <p>-The facility Executive Director was responsible for ensuring on-going compliance with the plan.</p> <p>-Other residents in the facility with orders for transmission-based precautions were reviewed to validate they were placed on appropriate transmission-based precautions.</p> <p>-Residents admitted to the facility since 11/1/24 were to be reviewed to validate that transmission-based precautions were implemented as appropriate, and PPE was available in the facility.</p> <p>-Findings of the above audits would be reviewed with the medical director.</p> <p>From 11/5/24 through 11/6/24 the IJ removal plan was verified as implemented by the survey team. No additional concerns related to the IJ situation were noted.</p> <p>1. Resident 30 readmitted to the facility on [DATE] with diagnoses including C-Diff. Resident 30 admitted without special infection control precautions and none were initiated until 11/4/24. On 11/4/24 Resident 30 was placed on enhanced barrier precautions for an open wound.</p> <p>On 11/5/24 at 10:50 AM Staff 2 (DNS) stated Resident 30 was admitted without special infection control precautions and none were initiated until 11/4/24, but for enhanced barrier precautions related to an open wound. Staff 2 stated Resident 30 was positive for C-Diff, but not placed on appropriate transmission-based precautions for C- Diff. A review of the EPA registered antimicrobial products effective against C-Diff spores revealed Mycolio (an alcohol based sanitize wipe), the product in use by the facility, was not an effective product to kill C-Diff spores.</p> <p>On 11/5/24 at 1:36 PM Staff 5 (CNA) entered Resident 30's room, took Resident 30's water cup, left her/his room with the cup and went to the water station with all the hydration supplies in the dining room including: multiple water pitchers, clean cups, and an ice chest with an ice scoop. Staff 5 returned the water to Resident 30 and did not wash her hands. Staff 5 stated she did not remove the hydration station cart from the dining room after filling Resident 30's water cup.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/5/24 at 1:52 PM Staff 5 stated management instructed staff PPE was required when coming into physical contact with an applicable resident. Staff 5 stated alcohol-based sanitizer was an acceptable means of hand hygiene after exiting a room with C-Diff precautions. Staff 5 stated the CNA on light duty did the vital sings on the 100 hall, including Resident 30, and used Mycolio disinfectant wipes to disinfect the vital equipment. Staff 5 stated she was told so many different things and she was confused on what the correct procedure was. No interventions were observed to address potential cross-contamination.</p> <p>On 11/5/24 at 1:53 PM Staff 7 (CNA) stated she used the Mycolio disinfectant wipes to disinfect the vital equipment.</p> <p>On 11/5/24 at 1:54 PM Staff 5, Staff 6 (CNA), Staff 7, and Staff 8 (CNA) stated they did not follow transmission-based precautions for C-Diff and furthermore did not demonstrate knowledge of appropriate precautions to prevent the spread of C-Diff.</p> <p>On 11/5/24 at 2:05 PM Staff 3 (Staff Development) provided an 10/2024 training on transmission-based precautions and stated 55% of staff did not complete the training as of 11/5/24.</p> <p>On 11/5/24 at 3:27 PM the front dining room was observed with the soiled water pitchers, cups, ice chest, and ice scoop still in place for residents to use.</p> <p>On 11/6/24 at 9:07 AM Staff 5 stated she gave Resident 30 a bed bath on 11/5/24. Staff 5 stated she washed the resident's hair, changed her/his hospital gown, and changed the bedding. Staff 5 stated she wiped down the resident's bedrail and mattress with Mycolio disinfectant wipes followed by personal wipes.</p> <p>On 11/6/24 at 9:12 AM Staff 41 (Housekeeping Manager) stated he was not informed Resident 30 no longer required transmission-based precautions. Staff 41 indicated a resident's room following C-Diff precautions would have curtains and linens removed and placed in a separate bag and the entire room cleaned and sanitized with bleach.</p> <p>On 11/6/24 at 9:26 AM Staff 2 was asked to identify all tasks completed when a resident was removed from contact precautions. Staff 2 did not include terminal cleaning of the resident's room, or the resident being showered.</p> <p>2. Resident 10 admitted to the facility in with a Stage 4 (severe damage to the skin, and the surrounding tissue begins to die) pressure ulcer.</p> <p>The 7/22/24 Admission MDS indicated Resident 10 was at high risk for developing another pressure ulcer due to malnutrition, incontinence, functional impairment and cognitive loss. Resident 10 was unable to execute major repositioning independently and relied on staff for assistance. The wound nurse provided wound care to Resident 10's pressure ulcer including measurements, assessment of the wound bed weekly with adjustment to the wound care orders as needed.</p> <p>On 11/6/24 at 9:45 AM Staff 11 (Resident Care Manager-LPN) was observed to perform wound care for Resident 10. During the dressing change the following was observed;</p> <p>-Staff 11 donned a gown and gloves without sanitizing her hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Staff 11 placed all clean dressing supplies including bandage scissors on Resident 10's bedside table which had incontinent pads and a urinal on top of the table. Staff 11 began touching drawers of the resident's nightstand to obtain more supplies and did not change her gloves.</p> <p>-Staff 11 then moved the clean supplies to Resident 10's bed on her/his incontinent pad and did not prepare a clean surface.</p> <p>-Staff 11 removed the resident's incontinent brief, removed the wound dressing, and cleansed the wound with her/his soiled gloves. Staff 11 proceeded to open the wound dressing packages with the same gloves, cut the new dressing with the soiled scissors and place the new dressings in the wound with the soiled gloves. Staff 11 used her fingers with donned with the soiled gloves instead of a clean Q-tip to place the dressing inside the wound.</p> <p>-Staff 11 proceeded to open another dressing package, cover the wound, reach into her pocket and obtain a permanent marker, write on the bandage, then place the pen back in her pocket.</p> <p>On 11/6/24 at 10:10 AM Staff 11 acknowledged she did not set-up a clean field for dressing supplies and did not change her gloves and sanitize her hands like she should have.</p> <p>On 11/6/24 at 10:30 AM Staff 9 (Regional Nurse) stated Staff 11 recently finished a wound class and should know to provide a clean area for dressings, change gloves and sanitize hands often when touching dirty dressings and applying clean dressings.</p> <p>3. Resident 19 admitted to the facility in 2/2022 with diagnoses including respiratory failure.</p> <p>A random observation on 11/8/24 at 8:24 AM revealed Staff 30 (LPN) reached into a resident's medication cup with multiple medications in the cup without sanitizing her hands or donning gloves, obtained a medication capsule from the cup, pulled the capsule apart, and placed the contents of the capsule in pudding.</p> <p>On 11/8/24 at 8:29 AM Staff 30 acknowledged she did not sanitize her hands or don gloves before she touched the resident's medications.</p> <p>41455</p> <p>4. Resident 27 admitted to the facility in 10/2023 with diagnoses including infection of the stomach lining and UTI.</p> <p>A 1/3/24 physician order revealed staff were to ensure Resident 27's colostomy (a surgical opening in the abdomen to divert waste out of the body) was emptied daily.</p> <p>An 10/23/24 revised care plan indicated to use enhanced barrier precautions for Resident 27 during high contact care activities including assistance with toileting.</p> <p>On 11/4/24 at 10:15 AM a sign was posted on Resident 27's door which indicated the resident required enhanced barrier precautions and staff were to wear gloves and a gown during high contact care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/4/24 at 10:17 AM Resident 27 stated staff often did not use gloves and gowns to change her/his colostomy bag and the last time PPE was used by staff was a few weeks earlier. No PPE was found near or in Resident 27's room.</p> <p>On 11/4/24 at 10:43 AM Staff 2 (DNS) confirmed PPE was required and not in place for staff to use during Resident 27's care.</p> <p>42270</p> <p>5. Resident 195 admitted to the facility in 10/2024 with diagnoses including C-Diff.</p> <p>An 10/26/24 order for Resident 195 revealed she/he received Vancomycin (an antibiotic) four times a day for enterocolitis (inflammation of the digestive track) due to C-Diff.</p> <p>Resident 195's Bowel Movements task revealed the following documented bowel movements:</p> <ul style="list-style-type: none"> <li>-10/27/24: 1 loose/diarrhea and 2 formed/normal</li> <li>- 10/29/24: 2 loose/diarrhea stool</li> <li>- 10/30/24: 3 loose/diarrhea stool</li> <li>- 10/31/24: 3 loose/diarrhea stool</li> <li>- 11/1/24: 2 loose/diarrhea stool, 1 formed/normal</li> <li>- 11/2/24: 3 loose/diarrhea stool</li> <li>- 11/3/24: 3 loose/diarrhea stool</li> <li>- 11/4/24: 1 loose/diarrhea stool, 1 formed/normal</li> <li>- 11/5/24: 2 loose/diarrhea stool, 1 formed/normal</li> </ul> <p>On 11/4/24 at 11:13 AM Resident 195 was observed in her/his room and there were no signs to indicate transmission based precautions or enhanced barrier precautions were needed.</p> <p>On 11/4/24 at 2:54 PM Staff 1 (Administrator) placed a sign on Resident 195's door which indicated she/he was on enhanced barrier precautions, and Staff 1 stated this was due to Resident 195's urostomy.</p> <p>On 11/6/24 at 9:05 AM Staff 2 (DNS) reviewed Resident 195 and stated she/he was not on transmission based precautions for C-Diff due to a negative C-Diff test and soft formed stools.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a joint interview on 11/6/24 at 9:26 AM Staff 2 and Staff 9 (Regional Nurse) were asked to review Resident 195. Staff 2 stated he was unable to access and provide the negative C-Diff test result for Resident 195. Staff 2 was asked to review the bowel records for Resident 195 due to the multiple documented loose/diarrhea stools. Staff 2 stated he would need to follow up with the corporate infection preventionist and the physician regarding the need for contact precautions due to C-Diff and active loose/diarrhea stools. Staff 9 stated the facility would immediately place Resident 195 on contact precautions until a determination was made.</p> <p>6. Resident 20 admitted to the facility in 10/2019 with diagnoses including diabetes.</p> <p>On 11/4/24 at 11:25 AM Staff 19 (Agency RN) was observed to check Resident 20's CBG (blood sugar measurement) level. After the CBG level was obtained Staff 19 wiped the glucometer with one alcohol prep pad and then placed the glucometer on top of the medication cart. When asked what her process was for cleaning and sanitizing the glucometer Staff 19 stated she cleaned the glucometer between each resident use with alcohol prep pads, as they were the only cleaning product provided.</p> <p>On 11/4/24 at 11:32 AM Staff 2 (DNS) confirmed an alcohol prep pad was not an appropriate method to clean and sanitize the glucometer.</p>		