STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Bluffs Park	355 Huron View Blvd Ann Arbor, MI 48103

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 This citation pertains to Intake MI00149652. Based on observation, interview, and record review, the facility failed to provide the necessary supplies to perform oral care for one (R5) of three reviewed. Findings include: Review of the medical record revealed R5 was admitted to the facility on [DATE]. The Brief Interview Status (BIMS-a cognitive screening tool) dated 1/31/25 revealed R5 scored 15 out of 15 (cognitively intact). On 2/3/25 at 11:34 AM, R5 was observed self-ambulating back to bed from the bathroom. R5 reported they had been in the facility for five days and had not been provided a toothbrush, toothpaste, or mouth wash and therefore had not had oral care since admission. On 2/4/25 at 9:16 AM, R5 was observed sitting on the edge of their bed. R5 reported they still had not received the necessary supplies to complete oral care. In an interview on 2/4/25 at 9:18 AM, Certified Nursing Assistant (CNA) F reported R5 required very light assistance with activities of daily living (ADL) and did most care independently. When asked about oral care, CNA F reported they believed R5 had the necessary supplies to complete their own oral care. CNA F then entered R5's room to locate oral care supplies. CNA F was unable to locate any supplies and asked R5 where the supplies were located. R5 then informed CNA F that oral care supplies had not been provided. Review of the Oral Care task reveled oral care had been documented as completed throughout R5's stay. In an interview on 2/4/25 at 1:00 PM, Director of Nursing (DON) B reported supplies given to new admissions included a basin with basic ADL supplies including toothpaste and a toothbrush.

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
	235658	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Bluffs Park	355 Huron View Blvd Ann Arbor, MI 48103

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** 32064 This citation pertains to Intake MI00149652. Based on interview and record review, the facility failed to follow-up on a change in vital signs for one (R2) of three reviewed. Findings include: Review of the medical record revealed R2 was admitted to the facility on [DATE] with diagnoses that included infection and inflammatory reaction due to cardiac and vascular devices, chronic obstructive pulmonary disease (COPD), history of cardiac arrest, and acute respiratory failure with hypoxia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/6/24 revealed R2 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician's Order dated 5/1/24 revealed an order for oxygen at 2 liters per minute continuously to maintain an oxygen level of 90% or better. This order was discontinued 6/24/24 as R2 was weaned off oxygen. Review of the Physician's Order dated 5/31/24 revealed check pulse ox (oximetry) on room air. Try to wean down/off oxygen one time a day for hypoxia. Review of the Medication Administration Record (MAR) revealed this order was scheduled for 9:00 AM every day. On 7/12/24 at 9:00 AM, R2's oxygen level was documented as 90%. Review of the Physician's Order dated 5/1/24 revealed an order for vital signs every day shift. According to the MAR, on 7/12/24, R2's oxygen level was documented as 85%. Review of the O2 Sats (Oxygen saturation) summary, on 7/12/24 at 9:03 AM, R2's oxygen level was 90% on room air (without the use of oxygen). On 7/12/24 at 3:41 PM, R2's oxygen level was documented as 85% on room air. On 7/12/24 at 8:00 PM, R2's oxygen level was documented as 83% on room air. In an interview on 2/3/25 at 2:30 PM, Registered Nurse (RN) C reported they worked day shift on 7/12/24. RN C reported R2 had been weaned off oxygen. RN C reported if an oxygen level below 90% was reported to them, they would follow up with their own assessment and notify the physician. According to the MAR, RN C documented the oxygen level of 90% at 9:00 AM and the oxygen level of 85% on 7/12/24. When asked about the oxygen level of 85%, RN C reported they could not recall what time that level was obtained. When asked if they were aware of the oxygen level below 90%, RN C stated they must not have been because they did not document any assessment or follow-up. RN C reported their shift ended at 7:30 PM on 7/12/24. Review of the medical record revealed no assessment of R2 after the oxygen level of 85% was documented. There was no documentation that oxygen was started or that the physician was notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235658	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Bluffs Park	355 Huron View Blvd Ann Arbor, MI 48103

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	Review of the Nurse's Note dated 7/12/24 at 11:51 PM written by Licensed Practical Nurse (LPN) D, revealed writer went into resident's room at 2000 (8:00 PM) and found resident unresponsive, writer assessed resident and vitals checked and residents' vitals at 2000 was bp [blood pressure] 96/45, O2 [oxygen] 83, hr [heartrate] 80, resp. [respirations] 24, and temp 96.1. Resident was lethargic and had sob [shortness of breath]. O2 administered via rebreather mask. Vitals at 2010 (8:10 PM) bp 100/44, hr 85, O2 91, vitals at 2014 (8:14 PM) [BP] 81/46, hr 71, O2 96. Resident transferred out to [hospital name]. R2 did not return to the facility. In a telephone interview on 2/4/25 at 12:07 PM, Certified Nursing Assistant (CNA) H reported they worked afternoon shift (3:00 PM until 11:00 PM) on 7/12/24 and that day R2 was Definitely more out of it. You could tell. CNA H reported shortly after their break, which was after dinner was served at approximately 6:00 PM, they witnessed RN C in R2's room with the bladder scan machine outside the room. CNA H reported RN C did not have the vitals machine in R2's room. CNA H reported after RN C left R2's room, they went in to see R2. CNA H stated they could tell R2 was out of it and stated I was calling his [R2's] name and he wasn't responding until I like shook him. CNA H reported it was after their next break that R2 was sent to the hospital. When asked about the 85% oxygen level they documented on 7/12/24 at 3:41 PM, CNA H reported that was the approximate time they usually obtained vitals. CNA H reported when an oxygen level was low, a warning would pop up on their screen indicating the vital sign was out of range and that would indicate they should notify the nurse. CNA H reported the warnings also went directly to the nurses. CNA H could not recall if they notified RN C of R2's oxygen level of 85%. In a telephone interview on 2/4/25 at 9:07 AM, LPN D reported their shift began at 7:00 PM on 7/12/24. LPN D reported they received report from the day shift nurse, but the report did not include anything abnormal for R2. LPN D reported during normal rounds, they entered R2's room at approximately 8:00 PM and found R2 unresponsive. LPN D reported R2 did not have oxygen in place. In an interview on 2/4/25 at 1:00 PM, Director of Nursing (DON) B reported the computer alerted CNAs of abnormal vital signs and the CNAs had to confirm it. DON B reported alerts also went into the medical record and showed in red. DON B reported an alert was sent if an oxygen level was below 90%. DON B reported the CNA should reported to the nurse and then the nurse should report to the physician. When asked about R2's oxygen level of 85% on 7/12/24 at 3:41 PM, DON B reported they would expect the CNA to notify the nurse and then the nurse to evaluate. DON B reported the follow-up/assessment should be documented in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Regency at Bluffs Park		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Huron View Blvd Ann Arbor, MI 48103	

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 This citation pertains to Intake MI00149652. Based on interview and record review, the facility failed to completed bladder scans and intermittent straight catheterization as ordered by the physician for one (R2) of two reviewed. Findings include: Review of the medical record revealed R2 was admitted to the facility on [DATE] with diagnoses that included retention of urine. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/6/24 revealed R2 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician's Order dated 6/14/24 revealed PVR [post void residual/bladder scan] q 6 hours [every 6 hours]. ISC [intermittent straight catheter] if greater than 250 cc [cubic centimeter/1 cc is equal to 1 milliliter] and notify [Nurse Practitioner]. Review of the Physician's Order dated 6/18/24 revealed Bladder Scan PVR Q6hours, if unable to void and greater than 250cc then straight cath and place note in [doctor] book. Review of the Resident, Family, Employee, and Visitor Assistance Form dated 6/6/24-6/7/24 revealed Nurses stating that they need to bladder scan (today) and yesterday .not return to complete bladder scan. The action to be taken revealed education with staff. Review of the Guest/Resident, Family, Employee, and Visitor Assistance Form dated 6/10/24 revealed Yesterday the nurse came in and asked me if I was ready for my cath [catheter]. I asked if she was going to scan me first and she said no. She asked if I was refusing my cath and I said until I get scanned. She left. I saw her one more time and asked if she was going to scan me so I could get cath'd & she said no. Next shift scanned & cath'd me. The action to be taken revealed Education to nurse on following order PVR q 6 [hours] ISC > 250 mL [over 250 milliliters]. Review of the Medication Administration Records (MAR) revealed the following: On 6/15/24 at 6:00 AM, R2's bladder scan was not completed, but R2 was catheterized for 224 mL. On 6/16/24 at 12:00 PM, R2's bladder scan was not completed, but R2 was catheterized for 149 mL. On 6/16/24 at 6:00 PM, R2's bladder scan was not completed, but R2 was catheterized for 215 mL. On 6/17/24 at 12:00 PM, R2's bladder scan was not completed, but R2 was catheterized for 102 mL. On 6/18/24 at 12:00 AM, R2's bladder scan result was 190 mL and R2 was catheterized for 500 mL. Per the order, R2's catheterization was to be performed if the bladder scan resulted in more than 250 mL. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER: Regency at Bluffs Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 355 Huron View Blvd Ann Arbor, MI 48103	

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 12:00 PM, R2's bladder scan was not completed. On 6/18/24 at 6:00 PM, R2's bladder scan was not completed. On 6/19/24 at 12:00 AM, R2's bladder scan result was 500 mL, but R2 was not catheterized as ordered. On 6/23/24 at 12:00 PM, R2's bladder scan was not competed, but R2 was catheterized for 172 mL. On 6/26/24 at 12:00 PM, R2's bladder scan was not completed, but R2 was catheterized for 223 mL. On 6/29/24 at 6:00 AM, R2's bladder scan result was 195 mL and R2 was catheterized for 300 mL. On 6/29/24 at 6:00 PM, R2's bladder scan was not completed. On 6/30/24 at 6:00 PM, R2's bladder scan result was 185 mL and R2 was catheterized for 220 mL. On 7/1/24 at 12:00 PM, R2's bladder scan was not completed. On 7/1/24 at 6:00 PM, R2's bladder scan result was 400 mL, but R2 was not catheterized. On 7/2/24 at 12:00 PM, R2's bladder scan was not completed. On 7/4/25 at 6:00 AM, R2's bladder scan result was 233 mL and R2 was catheterized for 295 mL. On 7/4/24 at 6:00 PM, R2's bladder scan result was 204 mL and R2 was catheterized for 200 mL. On 7/11/24 at 6:00 AM, R2's bladder scan result was 226 mL and R2 was catheterized for 246 mL. On 7/12/24 at 12:00 AM, R2's bladder scan result was 75 mL and R2 was catheterized for 100 mL. In an interview on 2/4/25 at 1:00 PM, Director of Nursing (DON) B agreed R2's bladder scans and intermittent straight catheterizations were not documented as being completed as ordered by the physician. DON B reported the facility had identified this as a concern and implemented corrective action. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included all nurse re-education on physician orders, post void residuals and intermittent straight catheter completion. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER: Regency at Bluffs Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 355 Huron View Blvd, Ann Arbor, MI 48103	

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 This citation pertains to Intake MI00149652. Based on interview and record review, the facility failed to notify the physician of urine culture results for one (R2) of one reviewed. Findings include: Review of the medical record revealed R2 was admitted to the facility on [DATE] with diagnoses that included retention of urine. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/6/24 revealed R2 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R2's urinalysis dated 6/3/24 revealed a urine culture was pending. Review of the Nurse Practitioner Note dated 6/4/24 revealed Urine positive for LE [leukocyte esterase] - Await culture as patient is asymptomatic. On 2/4/25 at 10:44 AM, R2's urine culture results were requested from Nursing Home Administrator (NHA) A. Review of the urine culture results collected 6/3/24 and resulted 6/6/24 revealed R2's urine culture was positive for over 100,000 cfu/mL (colony forming unit/milliliter) Klebsiella pneumoniae and over 100,000 cfu/mL Escherichia coli (E-coli). The results revealed they were obtained from the laboratory on 2/4/25 at 10:49 AM. R2's medical record did not reveal any documentation that the physician was notified of the abnormal urine culture results or that the physician acknowledged the results. In an interview on 2/4/25 at 1:00 PM, Director of Nursing (DON) B reported on 6/4/24 the Nurse Practitioner documented that R2's urinalysis was positive, and they would wait for the culture results. DON B reported they did not see where the physician was notified of the results or that they reviewed the urine culture results.

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235658	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Bluffs Park	355 Huron View Blvd Ann Arbor, MI 48103

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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 This citation pertains to Intake MI00149652. Based on interview and record review, the facility failed to ensure urine culture results were in the medical record for one (R2) of one reviewed. Findings include: Review of the medical record revealed R2 was admitted to the facility on [DATE] with diagnoses that included retention of urine. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/6/24 revealed R2 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R2's urinalysis dated 6/3/24 revealed a urine culture was pending. Review of the Nurse Practitioner Note dated 6/4/24 revealed Urine positive for LE [leukocyte esterase] - Await culture as patient is asymptomatic. R2's medical record did not include urine culture results. Review of the medical record revealed no documentation that R2's urine culture results were received. On 2/4/25 at 10:44 AM, R2's urine culture results were requested from Nursing Home Administrator (NHA) A. Review of the urine culture results collected 6/3/24 and resulted 6/6/24 revealed R2's urine culture was positive for over 100,000 cfu/mL (colony forming unit/milliliter) Klebsiella pneumoniae and over 100,000 cfu/mL Escherichia coli (E-coli). The results revealed they were obtained from the laboratory on 2/4/25 at 10:49 AM. In an interview on 2/4/25 at 1:00 PM, Director of Nursing (DON) B reported on 6/4/24 the Nurse Practitioner documented that R2's urinalysis was positive, and they would wait for the culture results. DON B reported they could not locate the culture results in R2's medical record but reported the physicians used a separate system where laboratory results synced into their system.