

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  04/23/2025
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)
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27306</p> <p>Based on observation, interview and record review the facility failed to ensure dignity was maintained for one resident (resident #52) of four residents reviewed for dignity.</p> <p>Review of the clinical record Resident # 52 (R52) was admitted to the facility on [DATE] with diagnosis that include compression fracture and cognitive deficit. Review of the Minimum Data Set (MDS) dated [DATE] revealed R52 scored 9 out of 15 (moderate cognitive) on Brief Interview Status Score for Mental Status (BIMS) .</p> <p>On 04/15/25 at 10:37 AM R52 was observed resting in bed, next to the bed was a recliner chair, a pillow was on the chair and on top of the pillow was a pile of un-bagged pile of linen smeared with feces. The pile of un-bagged soiled linen sat approximately 2 to 3 feet away from R52's face. R52 was observed again 31 minutes later with the soiled linen still on the reclining chair.</p> <p>On 04/23/25 at 12:40 PM, during an interview with Certified Nursing Assistant (CNA) R reported the process for providing care for an incontinent resident who also had soiled linen, first step was to meet the resident needs, by providing peri care, changing the brief , clothing linen etc CNA R reported all soiled linen would immediately be put in a bag then brought to then taken to soiled utility room. When queried if there would ever be a reason for soiled linen not to be bagged and placed on resident furniture. CNA R stated no, that shouldn't happen.</p> <p>On 04/23/25 01:02 PM during an interview with Director of Nursing (DON) B reported it was not protocol to leave soiled linen un-bagged and nest to a resident. DON B stated perhaps whoever assisted R52 that day forgot to get a bag.</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 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27446</p> <p>Based on observation, interview, and record review the facility failed to maintain resident dignity for three of three residents (Resident 25, 48, &amp; 51) resulting in feelings of anger, embarrassment, degrading, feeling not important.</p> <p>Findings Included:</p> <p>Resident 51 (R51):</p> <p>Per the facility face sheet R51 had resided at the facility since 7/23/2024.</p> <p>On 4/16/2025 at 2:58 PM, R51 was visited in his room. R51 stated that he wore a brief, but stated he knew when he had to urinate, and have a bowel movement. R51 said staff who put briefs on him have not ever offered to allow him to wear his own underwear, and said he was not sure if he even had underwear in his room with his own belongings. With permission R52's top dresser drawer was opened, and several pairs of underwear were observed to be in the drawer that were R51's underwear. R51 stated he had no idea those pairs of underwear were there in the drawer, and again stated no one had ever offered him to wear his own underwear instead of a brief. An urinal was observed to be at R51's bedside with urine in it. R51 said he can either go in the urinal or the toilet in the bathroom, and stated he was able to walk with his walker. R51 stated that he did not need to wear a brief it made him feel like an invalid, stated that he was a grown man, said he was embarrassed to wear the brief. R51 stated that one time, could not recall who the Certified Nurse Aid (CNA) was or the exact date, he asked for assistance to use the toilet and stated the CNA told him, (as quoted by R51), they did not have time to provide any care to me, and to have my bowel movement in my brief. R51 said he reply to the CNA, did you just tell me to poop in my pants?, and said the CNA said yes because no one had time to provide him with care, R51 said that made him saw wow. R51 said he was not able to comprehend what he was just told. R51 stated he was embarrassed, felt like no one cared about him, he did not matter, and again said he could not comprehend what he was just told. R51 stated that he wants the brief off, did not want to wear the briefs anymore, and no one had offered him to wear his own underwear. R51 further stated that he did not wear briefs prior to coming to the facility, he used the toilet, and did not want to wear them now.</p> <p>Resident #25 (R25):</p> <p>Per the facility face sheet R25 was originally admitted to the facility on [DATE].</p> <p>On 4/16/2025 at 3:29 PM, an attempt was made to visit R25 in her room. Upon knocking on R25's room door, R25 stated she was in the bathroom and would be available after she finished.</p> <p>In an interview on 4/17/2025 at 9:23 AM, R25 was visited in her room. R25 stated that she did make the statement in resident council in [DATE] that a CNA, could not recall who, told her that she did not have time to provide her with care, and told her to go to the bathroom in her brief.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of grievances revealed that on 2/6/2025 R25 put in a grievance that revealed, CNA told resident They do not have time, use the bathroom in their brief, Between 4pm-8pm .</p> <p>In an interview on 4/21/2025 at 11:07 AM, Administrator A stated that she was the abuse coordinator, and all abuse including allegations of abuse were to be reported to her immediately. Administrator A stated that psychosocial/mental harm is the way the resident was feeling and included dismissal of their feelings by staff.</p> <p>Administrator A stated that resident grievances would be placed into her mailbox but stated if nursing received the grievance it would go to Director of Nursing B (DON), who would then give it to the appropriate staff member to follow up on. Administrator A stated that she did read the grievances. Furthermore, Administrator A stated that she had read the resident grievances that they were told by CNAs that they did not have time to provide them care, and to go to the bathroom in their briefs. Administrator A stated she took the statements as an issue with customer care and not allegations of abuse.</p> <p>In an interview on 4/21/2025 at 12:06 PM, DON B stated that there were concerns about residents being told to go to the bathroom in their briefs. DON B stated that education was provided to CNAs, and said the grievances regarding the briefs were considered customer service concerns, and not allegations of abuse.</p> <p>Resident #48 (R48)</p> <p>Review of the medical record reflected R48 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/15/25, reflected R48 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 4/17/25 at 8:27 AM, R48 was observed in his room. R48 reported that call light response is incredibly long, and once he was denied assistance to use the bathroom for a bowel movement and was told to have a bowel movement in his brief while he was in bed. R48 described the situation as humiliating and degrading. R48 confirmed that he is occasionally incontinent of urine, however, continent of bowel and can report when he needs assistance to the bathroom. R48 stated that after that incident, he has forced himself to learn how to transfer himself to his wheelchair and assist himself to the bathroom, despite the need for staff assistance by one person. R48 stated that this became necessary so that he would never be made to have a bowel movement in his brief. R48 stated that he filled out a Grievance form related to this incident, however, never had any appropriate follow up or resolution for the concern and now just ensures that he self transfers to the bathroom for bowel movement. R48 stated that he feels like a second class citizen.</p> <p>Review of a Grievance form revealed R48's handwritten name at the top of the form with a concern which stated cna (certified nursing assistant) told resident they do not have time, use the bathroom in your brief.</p>		

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<p>F 0559</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 share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46954</p> <p>Based on observation, interview, and record review, the facility failed to provide advanced written notice prior to a room change for one Residents (#30), of one residents reviewed for room changes. Findings include:</p> <p>Resident #30 (R30)</p> <p>Review of the medical record reflected R30 was admitted to the facility on [DATE], with diagnoses that included difficulty in walking. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/19/25, reflected R30 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 4/15/25 at 10:30 AM, R30 was observed in her room resting in bed. R30 expressed frustration with the lack of communication at the facility. R30 stated that she has had several room changes and typically, staff would not give her any notice and would state that they were moving her that day. R30 stated she had a variety of roommates and questioned the compatibility of a few of her previous roommates.</p> <p>Review of R30's room change history revealed R30 had four room changes since admission on 2/28/25, 3/14,24, 3/20/25, and 4/2/25.</p> <p>Review of R30's room change notice evaluations reflected two room change notifications, one dated 3/14/25 and one dated 3/20/25.</p> <p>In an interview on 04/23/25 at 10:58 AM, Social Worker (SW) D stated that prior to a room change, staff should inform the resident of the room change and document the conversation in the room change evaluation. SW D was unable to locate the missing room change notifications for R30.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46954</p> <p>Based on observation, interview and record review, the facility failed to assess a seatbelt as potential restraint for one (Resident #10) of one reviewed.</p> <p>Resident #10 (R10)</p> <p>R10 admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included muscle wasting and atrophy and anoxic brain damage. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/2/25, reflected R10 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R10's Care Plan revealed R10 was dependent on two staff members with the use of a mechanical Hoyer lift for transfers.</p> <p>On 4/15/25 12:35 PM, R10 was observed in his room, sitting on a motorized wheelchair. R10 had a seatbelt across his lap. R10 was unable to self release his seatbelt. R10 stated due to limited use of only one hand, he knew he would not be able to release the seatbelt independently.</p> <p>R10 reported he had never been asked if he could release the seatbelt independently.</p> <p>In an interview on 04/18/25 at 10:19 AM, Certified Nursing Assistant (CNA) P stated that R10 was unable to unlatch his seatbelt.</p> <p>In an interview on 4/23/25 at 10:34 AM, CNA M stated that R10 was unable to unlatch his seatbelt.</p> <p>In an 4/18/25 at 10:36 AM, Therapy Director F reported that R10 had a physical restraint evaluation for the use of the seatbelt on his motorized power chair.</p> <p>Therapy Director F was unable to locate the physical restraint evaluation. One was then created after the interview due to surveyor intervention.</p> <p>A Physician order which stated Electric wheelchair for mobility with seat belt for proper positioning was created on 4/18/2025.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446</b></p> <p>Based on observation, interview, and record review the facility failed to ensure for 14 out of 14 residents (Resident # 5, 7, 13, 15, 18, 25, 37, 48, 51, 69, 333, 335, 340, 341) allegations of abuse were reported to the state agency.</p> <p>Findings Included:</p> <p>Resident #5 (R5):</p> <p>Review of the grievance log revealed that on 3/7/2025, R5 had put in a grievance that it took one and a half hours to get assistance to use the bathroom, and she had missed her shower two times. The grievance further revealed, I (R5) was told to get a private aid. NO! Hire more help. The resolution was to continue to hire more staff. Abuse was not identified, R5 refused to sign the facility's resolution.</p> <p>Resident #7 (R7):</p> <p>Review of the grievance log revealed that on 2/10/2025, R7's daughter put in a grievance that if R7 did not take a shower then she would have a refusal.</p> <p>No resolution was noted regarding showers.</p> <p>Resident #13 (R13):</p> <p>Review of the grievance log revealed that on 12/09/2024, R13 put in a grievance that she had gone to the kitchen and upon speaking with a staff member (did not reveal who the dietary staff member was) she was told that when she spoke with the staff member on the phone she had raised her voice, and she was not allowed to call the kitchen, and to stop calling everyday. The statement revealed that when R13 went to the kitchen to speak with the staff member the staff member would not come out of the kitchen to speak with her, but then told her that she was not going to do this, and then tried to slam the kitchen door.</p> <p>The resolution for the allegation of abuse was, discharged</p> <p>Resident #15 (R15):</p> <p>Review of a grievance log revealed that on 3/30/2025, R15 put in a grievance that she was told by a Certified Nurse Aid (CNA) that she was not dealing with this today and to suck it up. The statement also revealed that R15 was told to wait to go to the bathroom while others were being rounded on.</p> <p>Resolution was education to CNA, and remove CNA from case load (will not provide care to R15, but will for other residents).</p> <p>Resident #18 (R18):</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a grievance log revealed that on 2/5/2025, R18 put in a grievance that a CNA transferred her with a lift by herself, but the lift required two people, and reported that the CNA yelled at her.</p> <p>The resolution did not address the allegation of abuse with the CNA yelling at the resident.</p> <p>Resident #25 (R25):</p> <p>Per the facility face sheet R25 was originally admitted to the facility on [DATE].</p> <p>On 4/16/2025 at 3:29 PM, an attempt was made to visit R25 in her room. Upon knocking on R25's room door, R25 stated she was in the bathroom and would be available after she finished.</p> <p>In an interview on 4/17/2025 at 9:23 AM, R25 was visited in her room. R25 stated that she did make the statement in resident council in [DATE] that a CNA, could not recall who, told her that she did not have time to provide her with care, and told her to go to the bathroom in her brief.</p> <p>Review of grievances revealed that on 2/6/2025 R25 put in a grievance that revealed, CNA told resident They do not have time, use the bathroom in their brief, Between 4pm-8pm .</p> <p>Resident #37 (R37):</p> <p>Review of a grievance log revealed that on 10/20/2024, R37 put in a grievance that a CNA told her that .she wasn't going to change her.</p> <p>The resolution was a discussion with the resident, and to continue with receiving assistance as needed. No identifying of abuse was noted.</p> <p>Resident #51 (R51):</p> <p>Per the facility face sheet R51 had resided at the facility since 7/23/2024.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/2025 at 2:58 PM, R51 was visited in his room. R51 stated that he wore a brief, but stated he knew when he had to urinate, and have a bowel movement. R51 said staff who put briefs on him have not ever offered to allow him to wear his own underwear, and said he was not sure if he even had underwear in his room with his own belongings. With permission R52's top dresser drawer was opened, and several pairs of underwear were observed to be in the drawer that were R51's underwear. R51 stated he had no idea those pairs of underwear were there in the drawer, and again stated no one had ever offered him to wear his own underwear instead of a brief. An urinal was observed to be at R51's bedside with urine in it. R51 said he can either go in the urinal or the toilet in the bathroom, and stated he was able to walk with his walker. R51 stated that he did not need to wear a brief it made him feel like an invalid, stated that he was a grown man, said he was embarrassed to wear the brief. R51 stated that one time, could not recall who the Certified Nurse Aid (CNA) was or the exact date, he asked for assistance to use the toilet and stated the CNA told him, (as quoted by R51), they did not have time to provide any care to me, and to have my bowel movement in my brief. R51 said he reply to the CNA, did you just tell me to poop in my pants?, and said the CNA said yes because no one had time to provide him with care, R51 said that made him saw wow. R51 said he was not able to comprehend what he was just told. R51 stated he was embarrassed, felt like no one cared about him, he did not matter, and again said he could not comprehend what he was just told. R51 stated that he wants the brief off, did not want to wear the briefs anymore, and no one had offered him to wear his own underwear. R51 further stated that he did not wear briefs prior to coming to the facility, he used the toilet, and did not want to wear them now.</p> <p>Resident #69 (R69):</p> <p>Review of a grievance form dated 11/26/2024, revealed R69's daughter filled out the grievance which stated that staff told her if they did not have time then they would tell the R69 to go to the bathroom in her diaper.</p> <p>The resolution was staff education.</p> <p>Resident #333 (R333):</p> <p>Review of a grievance form dated 1/6/2025, revealed R333 filled out a grievance that he had asked a CNA to help him to the bathroom, but the CNA gave him a urinal instead, and then left his room. The statement revealed that R333 could not use a urinal, and wanted to use the bathroom.</p> <p>The resolution was education.</p> <p>Resident #335 (R335):</p> <p>Review of the grievance log revealed the on 10/18/2024, R335 put in a grievance that she had vomited while in an activity at around 2:30 PM, and stated that her wound bandages were saturated. R335 wrote on the grievance that a CNA told her that her wound dressings would not be changed until 6:00 or 7:00 PM.</p> <p>There was no documented resolution.</p> <p>Resident #340 (R340):</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a grievance form dated 6/14 and 6/15/2024 revealed, R340's CNA would not assist her to the bathroom, but just stood there and watched her walk unassisted, would not straighten her bed, and threw the bed covers over her.</p> <p>Resolution was the CNA was terminated.</p> <p>Resident #341(R341):</p> <p>Review of a grievance form dated 6/8 &amp; 6/9/2024, revealed R341 filled out a grievance which stated she had asked her CNA if she could help her with her colostomy bag, and the CNA just rolled her eyes at her and walked out. The form also revealed that the CNA had entered R341's room and rolled her eyes again when she saw R341 was not done eating her dinner.</p> <p>The resolution was the CNA was disciplined.</p> <p>In an interview on 4/21/2025 at 11:07 AM, Administrator A stated that she was the abuse coordinator, and all abuse including allegations of abuse were to be reported to her immediately. Administrator A stated that psychosocial/mental harm is the way the resident was feeling and included dismissal of their feelings by staff.</p> <p>Administrator A stated that resident grievances would be placed into her mailbox but stated if nursing received the grievance it would go to Director of Nursing B (DON), who would then give it to the appropriate staff member to follow up on. Administrator A stated that she did read the grievances. Furthermore, Administrator A stated that she had read the resident grievances that they were told by CNAs that they did not have time to provide them care, and to go to the bathroom in their briefs. Administrator A stated she took the statements as an issue with customer care and not allegations of abuse.</p> <p>In an interview on 4/21/2025 at 12:06 PM, DON B stated that there were concerns about residents being told to go to the bathroom in their briefs. DON B stated that education was provided to CNAs, and said the grievances regarding the briefs were considered customer service concerns, and not allegations of abuse.</p> <p>None of the allegations of abuse were reported to the state agency.</p> <p>Furthermore, review of the facility's policy and procedure titled, Care Program (grievances) dated 6/11/2024, revealed under Actions, If the concern is related to alleged abuse, neglect, and/or mistreatment the concerns should be forwarded immediately to the supervisor, administrator, and director of nursing.</p> <p>46954</p> <p>Resident #48 (R48)</p> <p>Review of the medical record reflected R48 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/15/25, reflected R48 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/17/25 at 8:27 AM, R48 was observed in his room. R48 reported that call light response is incredibly long, and once he was denied assistance to use the bathroom for a bowel movement and was told to have a bowel movement in his brief while he was in bed. R48 described the situation as humiliating and degrading. R48 confirmed that he is occasionally incontinent of urine, however, continent of bowel and can report when he needs assistance to the bathroom. R48 stated that after that incident, he has forced himself to learn how to transfer himself to his wheelchair and assist himself to the bathroom, despite the need for staff assistance by one person. R48 stated that this became necessary so that he would never be made to have a bowel movement in his brief. R48 stated that he filled out a Grievance form related to this incident, however, never had any appropriate follow up or resolution for the concern and now just ensures that he self transfers to the bathroom for bowel movement. R48 stated that he feels like a second class citizen.</p> <p>Review of a Grievance form revealed R48's handwritten name at the top of the form with a concern which stated cna (certified nursing assistant) told resident they do not have time, use the bathroom in your brief.</p>		

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NAME OF PROVIDER OR SUPPLIER  Regency at Bluffs Park		STREET ADDRESS, CITY, STATE, ZIP CODE  355 Huron View Blvd Ann Arbor, MI 48103	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27446</p> <p>Based on observation, interview, and record review the facility failed to ensure for 14 out of 14 residents (Resident # 5, 7, 13, 15, 18, 25, 37, 48, 51, 69, 333, 335, 340, 341) allegations of abuse were identified and investigated.</p> <p>Findings Included:</p> <p>Resident #5 (R5):</p> <p>Review of the grievance log revealed that on 3/7/2025, R5 had put in a grievance that it took one and a half hours to get assistance to use the bathroom, and she had missed her shower two times. The grievance further revealed, I (R5) was told to get a private aid. NO! Hire more help.</p> <p>The resolution was to continue to hire more staff. Abuse was not identified, R5 refused to sign the facility's resolution.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #7 (R7):</p> <p>Review of the grievance log revealed that on 2/10/2025, R7's daughter put in a grievance that if R7 did not take a shower then she would have a refusal.</p> <p>No resolution was noted regarding showers.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #13 (R13):</p> <p>Review of the grievance log revealed that on 12/09/2024, R13 put in a grievance that she had gone to the kitchen and upon speaking with a staff member (did not reveal who the dietary staff member was) she was told that when she spoke with the staff member on the phone she had raised her voice, and she was not allowed to call the kitchen, and to stop calling everyday. The statement revealed that when R13 went to the kitchen to speak with the staff member the staff member would not come out of the kitchen to speak with her, but then told her that she was not going to do this, and then tried to slam the kitchen door.</p> <p>The resolution for the allegation of abuse was, discharged</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #15 (R15):</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a grievance log revealed that on 3/30/2025, R15 put in a grievance that she was told by a Certified Nurse Aid (CNA) that she was not dealing with this today and to suck it up. The statement also revealed that R15 was told to wait to go to the bathroom while others were being rounded on.</p> <p>Resolution was education to CNA, and remove CNA from case load (will not provide care to R15, but will for other residents).</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #18 (R18):</p> <p>Review of a grievance log revealed that on 2/5/2025, R18 put in a grievance that a CNA transferred her with a lift by herself, but the lift required two people, and reported that the CNA yelled at her.</p> <p>The resolution did not address the allegation of abuse with the CNA yelling at the resident.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #25 (R25):</p> <p>Per the facility face sheet R25 was originally admitted to the facility on [DATE].</p> <p>On 4/16/2025 at 3:29 PM, an attempt was made to visit R25 in her room. Upon knocking on R25's room door, R25 stated she was in the bathroom and would be available after she finished.</p> <p>In an interview on 4/17/2025 at 9:23 AM, R25 was visited in her room. R25 stated that she did make the statement in resident council in [DATE] that a CNA, could not recall who, told her that she did not have time to provide her with care, and told her to go to the bathroom in her brief.</p> <p>Review of grievances revealed that on 2/6/2025 R25 put in a grievance that revealed, CNA told resident They do not have time, use the bathroom in their brief, Between 4pm-8pm .</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #37 (R37):</p> <p>Review of a grievance log revealed that on 10/20/2024, R37 put in a grievance that a CNA told her that .she wasn't going to change her.</p> <p>The resolution was a discussion with the resident, and to continue with receiving assistance as needed. No identifying of abuse was noted.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #51 (R51):</p> <p>Per the facility face sheet R51 had resided at the facility since 7/23/2024.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/2025 at 2:58 PM, R51 was visited in his room. R51 stated that he wore a brief, but stated he knew when he had to urinate, and have a bowel movement. R51 said staff who put briefs on him have not ever offered to allow him to wear his own underwear, and said he was not sure if he even had underwear in his room with his own belongings. With permission R52's top dresser drawer was opened, and several pairs of underwear were observed to be in the drawer that were R51's underwear. R51 stated he had no idea those pairs of underwear were there in the drawer, and again stated no one had ever offered him to wear his own underwear instead of a brief. An urinal was observed to be at R51's bedside with urine in it. R51 said he can either go in the urinal or the toilet in the bathroom, and stated he was able to walk with his walker. R51 stated that he did not need to wear a brief it made him feel like an invalid, stated that he was a grown man, said he was embarrassed to wear the brief. R51 stated that one time, could not recall who the Certified Nurse Aid (CNA) was or the exact date, he asked for assistance to use the toilet and stated the CNA told him, (as quoted by R51), they did not have time to provide any care to me, and to have my bowel movement in my brief. R51 said he reply to the CNA, did you just tell me to poop in my pants?, and said the CNA said yes because no one had time to provide him with care, R51 said that made him saw wow. R51 said he was not able to comprehend what he was just told. R51 stated he was embarrassed, felt like no one cared about him, he did not matter, and again said he could not comprehend what he was just told. R51 stated that he wants the brief off, did not want to wear the briefs anymore, and no one had offered him to wear his own underwear. R51 further stated that he did not wear briefs prior to coming to the facility, he used the toilet, and did not want to wear them now.</p> <p>Resident #69 (R69):</p> <p>Review of a grievance form dated 11/26/2024, revealed R69's daughter filled out the grievance which stated that staff told her if they did not have time then they would tell the R69 to go to the bathroom in her diaper.</p> <p>The resolution was staff education.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #333 (R333):</p> <p>Review of a grievance form dated 1/6/2025, revealed R333 filled out a grievance that he had asked a CNA to help him to the bathroom, but the CNA gave him a urinal instead, and then left his room. The statement revealed that R333 could not use a urinal, and wanted to use the bathroom.</p> <p>The resolution was education.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #335 (R335):</p> <p>Review of the grievance log revealed the on 10/18/2024, R335 put in a grievance that she had vomited while in an activity at around 2:30 PM, and stated that her wound bandages were saturated. R335 wrote on the grievance that a CNA told her that her wound dressings would not be changed until 6:00 or 7:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documented resolution.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #340 (R340):</p> <p>Review of a grievance form dated 6/14 and 6/15/2024 revealed, R340's CNA would not assist her to the bathroom, but just stood there and watched her walk unassisted, would not straighten her bed, and threw the bed covers over her.</p> <p>Resolution was the CNA was terminated.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>Resident #341(R341):</p> <p>Review of a grievance form dated 6/8 &amp; 6/9/2024, revealed R341 filled out a grievance which stated she had asked her CNA if she could help her with her colostomy bag, and the CNA just rolled her eyes at her and walked out. The form also revealed that the CNA had entered R341's room and rolled her eyes again when she saw R341 was not done eating her dinner.</p> <p>The resolution was the CNA was disciplined.</p> <p>No investigation for an allegation of abuse was conducted.</p> <p>In an interview on 4/21/2025 at 11:07 AM, Administrator A stated that she was the abuse coordinator, and all abuse including allegations of abuse were to be reported to her immediately. Administrator A stated that psychosocial/mental harm is the way the resident was feeling and included dismissal of their feelings by staff.</p> <p>Administrator A stated that resident grievances would be placed into her mailbox but stated if nursing received the grievance it would go to Director of Nursing B (DON), who would then give it to the appropriate staff member to follow up on. Administrator A stated that she did read the grievances. Furthermore, Administrator A stated that she had read the resident grievances that they were told by CNAs that they did not have time to provide them care, and to go to the bathroom in their briefs. Administrator A stated she took the statements as an issue with customer care and not allegations of abuse.</p> <p>In an interview on 4/21/2025 at 12:06 PM, DON B stated that there were concerns about residents being told to go to the bathroom in their briefs. DON B stated that education was provided to CNAs, and said the grievances regarding the briefs were considered customer service concerns, and not allegations of abuse.</p> <p>None of the allegations of abuse were identified as allegations of abuse, and no investigations were conducted.</p> <p>46954</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #48 (R48)</p> <p>Review of the medical record reflected R48 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/15/25, reflected R48 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 4/17/25 at 8:27 AM, R48 was observed in his room. R48 reported that call light response is incredibly long, and once he was denied assistance to use the bathroom for a bowel movement and was told to have a bowel movement in his brief while he was in bed. R48 described the situation as humiliating and degrading. R48 confirmed that he is occasionally incontinent of urine, however, continent of bowel and can report when he needs assistance to the bathroom. R48 stated that after that incident, he has forced himself to learn how to transfer himself to his wheelchair and assist himself to the bathroom, despite the need for staff assistance by one person. R48 stated that this became necessary so that he would never be made to have a bowel movement in his brief. R48 stated that he filled out a Grievance form related to this incident, however, never had any appropriate follow up or resolution for the concern and now just ensures that he self transfers to the bathroom for bowel movement. R48 stated that he feels like a second class citizen.</p> <p>Review of a Grievance form revealed R48's handwritten name at the top of the form with a concern which stated cna (certified nursing assistant) told resident they do not have time, use the bathroom in your brief.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46954</p> <p>Based on observation, interview, and record review, the facility failed to ensure showers were offered and completed per resident preference for one out of four residents (Resident #30). Findings include:</p> <p>Resident #30 (R30)</p> <p>Review of the medical record reflected R30 was admitted to the facility on [DATE], with diagnoses that included difficulty in walking. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/19/25, reflected R30 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 4/15/25 at 10:30 AM, R30 was observed in her room resting in bed. R30 expressed frustration with the lack of communication at the facility. R30 stated that she has had several room changes and typically, staff would not give her any notice and would state that they were moving her that day. R30 also stated that due to the constant room changes, she believes her shower days were mixed up, therefore, R30 had missed some of her scheduled shower days. R30 added that staff were offering her showers at unreasonable times in the evening, resulting in a refusal for a shower and on once instance, a shower was offered after her dressing changes were completed. R30 denied refusing other showers. R30 was unsure of what her scheduled shower days were.</p> <p>Review of R30's shower task documentation reflected the following:</p> <p>3/22/25 refused, per shower sheet, R30 did not know about her shower in advanced, too late now.</p> <p>3/26/25 refused, no refusal shower sheet</p> <p>3/29/25 refused, legs wrapped per shower sheet</p> <p>4/9/25 refused per shower sheet she said she had one yesterday</p> <p>4/12/25 marked no shower</p> <p>4/22/25 refusal, no shower sheet for refusal</p> <p>In an interview on 04/23/25 at 12:47 PM, Director of Nursing (DON) B stated that the expectation for showers was to document the refusal in the medical record, and/or document the refusal on a shower sheet. DON B stated that staff should not be marking no in the shower task ands should be offering showers per the shower schedule.</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> 46954</p> <p>Based on observation, interview and record review, the facility failed to ensure prevention of a fall for one (Resident #10) of two reviewed for falls. Findings include:</p> <p>Resident #10 (R10)</p> <p>R10 admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included muscle wasting and atrophy and anoxic brain damage. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/2/25, reflected R10 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R10's Care Plan revealed R10 was dependent on two staff members with the use of a mechanical Hoyer lift for transfers.</p> <p>On 4/15/25 12:35 PM, R10 was observed in his room, sitting on a motorized wheelchair. R10 had a seatbelt across his lap. R10 reported that he fell out of chair recently. R10 explained that staff had transferred him to his wheelchair and after being placed in his wheelchair, staff had forgotten to put the armrest on his chair down. R10 stated that he has no trunk control, weakness on his left side of his body, and very limited use of his right side of the body. R10 stated that the staff member had moved on with his care duties and due to the armrest being up, he fell sideways out of his chair and suffered a hematoma to his head. R10 stated that he was transferred to the hospital.</p> <p>Review of an Incident report dated 3/1/25 revealed R10 had a fall out of his wheelchair and sustained an injury to the left side of his head. The resident description of the fall indicated that the left arm rest of the wheelchair was up when he was placed in his chair, causing him to fall out of the left side of his wheelchair. The intervention included to have the left arm rest of his wheelchair down during transfers.</p> <p>Review of a Seating and Mobility Evaluation dated 7/12/24 revealed R10 could not independently maintain a neutral upright posture and had poor posture when sitting.</p> <p>In an interview on 4/17/25 at 10:02 AM, Certified Nursing Assistant (CNA) O stated she was assisting with R10's transfer the day that he fell . CNA O reported that after assisting CNA M with the transfer, she removed the Hoyer lift from R10's room and heard the sound of R10 falling. CNA O stated that typically she stays and assists with transfers, however, she was assigned to a different hall that shift and had several call lights activated and had to report back to her assigned area. CNA O reentered the room and observed R10 on the floor on the left side of the chair. CNA O stated that R10 is very weak, with very little trunk control so it is important to ensure that the arm rests are down on the chair before you leave R10's side. CNA O indicated that she did not feel that the CNA's had sufficient training on how to transfer him into the motorized wheelchair. CNA O stated that after the fall, the facility trained the staff on how to safely transfer R10 to the motorized wheelchair</p> <p>(continued on next page)</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>In an interview on 4/23/25 at 10:34 AM, CNA M stated that he was present when R10 experienced the fall. CNA M stated that he used the Hoyer lift to transfer R10 to his motorized wheelchair and reported that it was his first time transferring R10 to this particular chair. CNA M confirmed that R10 had no trunk control and due to the left arm rest being left up after the transfer, R10 fell sideways out of the chair and hit his head. CNA M stated he had no training prior to this and had no idea that the arm rest needed to be down to prevent R10 from falling out.</p> <p>In an interview on 04/23/25 at 12:50 PM, Director of Nursing (DON) B stated that R10 was placed into his motorized wheelchair, however, the arm rest was not down and due to the lack of core strength, R10 fell sideways out of his wheelchair. DON B stated that staff education to ensure arm rests were down when R10 was in the motorized chair was provided after the fall.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38383</p> <p>Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff to respond to resident needs timely for five of 15 reviewed (R1, R14, R22, R48 and R62).</p> <p>Findings include:</p> <p>In an interview on 4/15/25 at 10:23 AM, Certified Nurse Aide (CNA) C reported they were caring for 16 residents that shift (day shift), and their ability to keep up with resident care needs was dependent upon acuity levels.</p> <p>Resident #22 (R22):</p> <p>Review of the medical record reflected R22 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included fusion of the spine and dependence on renal dialysis.</p> <p>On 4/15/25 at 10:45 AM, R22 was observed in bed and reported slow response time when they used their call light. R22 reported they had waited 45 minutes or longer for staff assistance, three to four times, primarily on day shift. R22 reported they were typically calling to request pain medication.</p> <p>On 4/15/25 at 1:02 PM, R22 was observed seated in a wheelchair, in their room. R22 reported their call light had just been on for 50 minutes, and the nurse had not yet been back with their medication.</p> <p>Resident #1 (R1)</p> <p>Review of the medical record reflected R1 admitted to the facility on [DATE].</p> <p>On 4/15/25 at 3:05 PM, R1 was observed in bed. They reported between the hours of 8:00 PM and 8:00 AM, it took 30 minutes for staff to respond to their call light.</p> <p>27306</p> <p>On 04/16/25 at 02:20 PM during an interview with Licensed Practical Nurse U and V they reported the facility was understaffed and there was not enough Certified Nursing Assistants (CNA's) to meet the needs of the residents. During this interview CNA T interrupted the interview reporting to LPN U and LPN V that she could not locate the other CNA that was assigned to the same hall. CNA T elaborated that she was fed up with the other CNA because they always hide and do not take care of their assigned residents leaving CNA T with her residents (approximately 15 residents) and the other CNA's assignment (another 15 residents) CNA T stated she cant take care of 30 residents.</p> <p>46954</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/15/25 at 10:22 AM, Resident 14 (R14) was observed in their room. R14 stated that staffing is not good and it creates a delay in receiving her pain medication timely which impacts her physical therapy progress.</p> <p>On 4/15/25 at 10:00 AM, Resident #48 (R48) stated that there are significant call light response delays in the afternoon and midnights. Staff will tell R48 to shut his call light off and state they will be back, however, they do not return. R48 states it is an ongoing concern that is repeatedly brought up in Resident Council, however, nothing has been resolved. R48 states he hears other residents yelling out for help nearly every night.</p> <p>On 4/15/25 at 12:48 PM, Resident #62 stated that it takes staff up to an hour to answer his call light. R62 states he fears for the time that he experiences an actual emergency because he doubts staff will answer is call for help promptly.</p> <p>In an interview on 4/18/25 at 9:29 AM, Certified Nursing Assistant (CNA) L stated that it is difficult to find an additional CNA to assist with two person transfers and that he is unable to take his breaks due to insufficient staffing.</p> <p>In an interview on 4/18/25 at 10:19 AM, CNA P stated that current staffing levels make their job, really, really hard. CNA P states sometimes she has up to 18 residents and they often get really mad at you because of call light response times. CNA P states that she is constantly apologizing for the wait. CNA P stated that they are unable to take any breaks.</p> <p>In an interview on 4/17/25 at 10:02 AM, CNA O stated that staffing is poor and with the amount of resident needs required and the absence of sufficient staffing numbers, the job can be overwhelming and there is a likelihood in an increase of accidents.</p> <p>In an interview on 4/23/25 at 10:34 AM, CNA M stated that CNA's would instruct residents to use the bathroom in their brief as a time saving measure.</p>		

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

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22050</p> <p>Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 58 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage.</p> <p>Findings include:</p> <p>On 04/15/25 at 09:24 A.M., An initial tour of the food service was conducted with Dietary Manager G. The following items were noted:</p> <p>The Juice Machine interior surfaces (backsplash, undersplash, drip tray assembly) were observed soiled with accumulated and encrusted food residue. Dietary Manager G indicated she would have staff thoroughly clean and sanitize the Juice Machine as soon as possible.</p> <p>The Vulcan stove/oven backsplash and stove top burners were observed soiled (black) with accumulated and encrusted carbonized/caramelized food residue. The Vulcan interior and exterior surfaces were also observed soiled with accumulated and encrusted food residue. The Vulcan convection oven side exterior surface was further observed soiled (black) with accumulated and encrusted food residue. Dietary Manager G indicated she would have staff thoroughly clean and sanitize the Vulcan stove/oven as soon as possible.</p> <p>The can opener assembly was observed soiled with accumulated and encrusted food residue. Dietary Manager G indicated she would have staff thoroughly clean and sanitize the can opener assembly as soon as possible.</p> <p>The [NAME] stand mixer support table surface was observed heavily soiled with accumulated and encrusted food residue. Dietary Manager G indicated she would have staff thoroughly clean and sanitize the [NAME] stand mixer support table as soon as possible.</p> <p>The M3 Turbo Air refrigerator exterior surfaces were observed soiled with accumulated and encrusted food residue. Dietary Manager G indicated she would have staff thoroughly clean and sanitize the M3 Turbo Air refrigerator exterior surfaces as soon as possible.</p> <p>The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>The Vulcan stove/oven door handles were observed loose-to-mount. Dietary Manager G indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The 2022 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened.</p> <p>The food preparation sink faucet assembly was observed leaking water from the spout. The hot water and cold-water supplies could not be shut completely off, allowing a continuous water stream. Dietary Manager G indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>The 2022 FDA Model Food Code section 5-205.15 states: A plumbing system shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.</p> <p>The mechanical dish machine wash temperature digital display screen was observed to read 130.1 degrees Fahrenheit during the cleaning cycle.</p> <p>The 2022 FDA Model Food Code section 4-501.110 states: (A) The temperature of the wash solution in spray type warewashers that use hot water to SANITIZE may not be less than: (1) For a stationary rack, single temperature machine, 74oC (165oF); (2) For a stationary rack, dual temperature machine, 66oC (150oF); (3) For a single tank, conveyor, dual temperature machine, 71oC (160oF); or (4) For a multitank, conveyor, multitemperature machine, 66oC (150oF). (B) The temperature of the wash solution in spray-type warewashers that use chemicals to SANITIZE may not be less than 49oC (120oF).</p> <p>On 04/15/25 at 10:30 A.M., An interview was conducted with Registered Dietician H regarding the mechanical dish machine warewashing temperature. Registered Dietician H indicated the facility had a contractual service for maintaining the mechanical dish machine.</p> <p>On 04/17/25 at 10:00 A.M., Record review of the Policy/Procedure entitled: Maintenance and Repairs of Equipment in Nutritional Services Department dated 12/19/2024 revealed under Policy: It is the policy of this facility that all malfunctions and need for repairs are reported to the Maintenance Department and the Administrator in a timely manner. Record review of the Policy/Procedure entitled: Maintenance and Repairs of Equipment in Nutritional Services Department dated 12/19/2024 further revealed under Procedure: (1) The Nutritional Professional will be notified when a piece of equipment malfunctions. (2) The Nutritional Professional will notify the Maintenance Department in writing of the equipment issue (or via TELS program). The Nutritional Professional will also notify the Administrator. (3) If the repair requires outside servicing, the Nutritional Professional will schedule this in conjunction with the Maintenance Director and Administrator. (4) Preventative maintenance will be completed for major equipment at regular intervals. The Nutritional Professional and Maintenance Department will be responsible to coordinate these projects.</p> <p>On 04/17/25 at 10:15 A.M., Record review of the Policy/Procedure entitled: Dietary Cleaning and Sanitation dated 11/12/2021 revealed under Policy: It is the policy of this facility to maintain the sanitation of the kitchen through proper cleaning and sanitizing stationary food service equipment and food contact surfaces to minimize the growth of microorganisms that may result in food contamination. Food-contact surfaces are washed, rinsed, and sanitized: (a) After each use., (b) Before switching preparation to another food type., (c) When the tool or items being used may have been contaminated.</p>		

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

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383</b></p> <p>Based on observation, interview and record review, the facility failed to provide Occupational Therapy (OT) services as ordered for one (R22) of two reviewed.</p> <p>Findings include:</p> <p>Review of the medical record reflected R22 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included fusion of the spine and dependence on renal dialysis. At the time of review, R22's Admission/Medicare 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/10/25 was In Progress.</p> <p>On 4/15/25 at 10:50 AM, R22 was observed in bed, wearing a Miami J cervical collar (type of neck brace). R22 reported they were supposed to receive Physical Therapy (PT) and OT five times per week, for one hour per day, but were receiving less. R22 reported the facility was discussing discharge due to lack of progress and stated, how can I progress if they don't work with me more?</p> <p>In an interview on 4/17/25 at 9:48 AM, Physical Therapist (PT) E reported there were times therapy was unable to work with R22 during the week due to dialysis. It was reported the facility tried to adjust R22's therapy schedule around outside appointments, as well as provide therapy on the weekends. PT E reported R22 had an OT evaluation on 4/4/25 and received OT treatment/services on 4/5/25, 4/7/25, 4/8/25, 4/9/25, 4/10/25 and 4/11/25.</p> <p>R22's Physician Orders reflected they were to receive OT services six times per week for 12 weeks. R22's OT evaluation, dated 4/4/25, reflected they were to receive OT services five times per week for 12 weeks.</p> <p>In an interview on 4/17/25 at 10:27 AM, Therapy Director (TD) F reported OT was working on standing balance, bathing, toileting and commode transfers, upper extremity strengthening and activities of daily living (ADLs). TD F reported R22's orders were to receive OT five times per week, as noted on their therapy evaluations. According to TD F, they had to shift R22's therapy days and minutes due to not having OT staff in the facility. R22 was still on OT caseload at the time of the interview.</p> <p>On 4/17/25, review of R22's OT Service Log reflected they had not received any OT services since 4/11/25.</p>

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<p>F 0867</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>27446</p> <p>Based on interview and record review the facility failed to implement an effective Quality Assurance Performance Improvement Committee (QAPI) plan to address allegations of abuse from resident grievances.</p> <p>Findings Included:</p> <p>Review of resident concern/grievance logs revealed since June of 2024 there had been 15 grievances by 15 residents that were not identified as allegations of abuse.</p> <p>Per the facility's Quality Assurance Performance Improvement Committee (QAPI) policy and procedure dated 4/5/2024, revealed under Procedure #6 a list of reports and logs the committee used for improvement priorities and facility-identified concerns. Resident concern summary logs were listed.</p> <p>In an interview on 4/23/2025 at 1:05 PM, Administrator A stated that the QAPI committee met monthly. Administrator A stated that all required members attended all meetings. Administrator A stated that at the time there were no performance improvement plans (PIP) in place, and stated that allegations of abuse had not been identified as a concern with the QAPI committee.</p> <p>Review of the last QAPI meeting dated 4/9/2025 revealed, 7 .Concern Resolution- need to improve the turn around on form completion. No discussion was held regarding allegations of abuse or the number of resident allegations, and abuse was not identified but the committee upon review of the resident concerns.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</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** 38383</b></p> <p>Based on observation, interview and record review, the facility failed to 1) ensure appropriate use of Personal Protective Equipment (PPE) for one (R7) of three reviewed for Transmission-Based Precautions (TBP); and 2) ensure appropriate hand hygiene.</p> <p>Findings include:</p> <p>Resident #7 (R7):</p> <p>Review of the medical record reflected R7 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included pain in thoracic spine and chronic obstructive pulmonary disease. The admission/Medicare 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/2/25, reflected R7 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 04/15/25 at 12:20 PM, R7's room door was observed to be open, with a droplet precaution sign and PPE hanging on the exterior of the door. Two staff members were observed in the room, each wearing a gown, gloves and an N95 mask. Neither of the staff members were observed wearing eye protection. At 12:23 PM, one staff member exited R7's room, wearing an N95 mask with a surgical mask beneath it. The staff member proceeded to walk through the hallway with both masks in place. At 12:27 PM, the staff member returned to R7's room with face shields and was observed wearing a surgical mask.</p> <p>In an interview on 04/15/25 at 2:43 PM, Director of Nursing (DON) B reported R7 was in Transmission-Based Precautions due to being tested for COVID-19. DON B reported a gown, gloves, N95 mask and face shield were to be worn in R7's room. According to DON B, the gown and gloves were to be removed prior to exiting the room. The face shield was to be disinfected, and the N95 was to be removed in the hallway, immediately upon exiting the room.</p> <p>On 04/16/25 at 9:41 AM, a droplet precaution sign and PPE were observed hanging on the exterior of R7's room door. R7 was observed in bed, wearing oxygen via nasal cannula. R7 reported they did not know why they were placed in TBP but expressed they wish they had been notified.</p> <p>A Progress Note for 4/16/25 at 10:14 AM reflected R7's respiratory panel was negative. The medical record reflected isolation (TBP) was discontinued on 4/16/25 due to a negative COVID-19 test.</p> <p>According to the Centers for Disease Control and Prevention, .HCP [Healthcare Personnel] who enter the room of a patient with suspected or confirmed SARS-CoV-2 [COVID-19] infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) .</p> <p>(<a href="https://www.cdc.gov/covid/hcp/infection-control/index.html">https://www.cdc.gov/covid/hcp/infection-control/index.html</a>)</p> <p>45135</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 04/23/25 at 9:00AM, Licensed Practical Nurse (LPN) S was preparing medications to administer to R14. LPN S completed his preparation and picked up the medication cup and a glass of water and walked into R14's room. LPN S observed R14 take her oral pill form medications. LPN S did not was perform hand hygiene before or after entering R14s room and went back to the medication cart and started preparing the next residents medications.</p> <p>During an interview and observation on 04/23/25 at 9:25AM, LPN S preparing medications to administer to R10. LPN S completed his preparation, stated this resident was on contact precautions due to having Covid. LPN S begun donning up by putting on a disposable blue gown, he already had a blue surgical mask on, and did not change it, then put on gloves before going into the room. LPN S did not perform hand hygiene before putting on his gloves as the recommendation on R10's door. LPN S administered the medications and started to exit the room after removing the disposable gown, and gloves. LPN S did not remove and replace his blue surgical mask that he had been wearing prior to going into R10's room, and now after being in R10's room. LPN S did not follow the recommendation for the use of PPE for R10 or follow the policy and procedure for providing care to a resident on contact precautions, increasing the risk of cross contamination to other residents.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22050</p> <p>Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 60 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, reduced air quality, and potential cross-connections between the potable (drinking) and non-potable (non-drinking) water supplies.</p> <p>Findings include:</p> <p>On 04/16/25 at 08:30 A.M., A common area environmental tour was conducted with Maintenance Director I. The following items were noted:</p> <p>Jefferson</p> <p>Shower Room: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. Maintenance Director I indicated he would have housekeeping thoroughly clean and sanitize the soiled grill assembly as soon as possible.</p> <p>[NAME]</p> <p>Staff Break Room: The Men's and Women's Restroom return-air-exhaust ventilation grills were observed soiled with accumulated and encrusted dust/dirt deposits. Maintenance Director I indicated he would have housekeeping thoroughly clean and sanitize the soiled grill assemblies as soon as possible.</p> <p>[NAME]</p> <p>Resident/Visitor Restroom: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. Maintenance Director I indicated he would have housekeeping thoroughly clean and sanitize the soiled grill assembly as soon as possible.</p> <p>Occupational Therapy/Physical Therapy: 1 of 3 oval mobile chairs were observed (etched, scored, particulate), exposing the inner Styrofoam padding. The damaged surface measured approximately 1-inch-wide by 3-inches-long twice. Maintenance Director I indicated he would remove and replace the damaged chair as soon as possible.</p> <p>Nursing Station: 1 of 2 chairs were observed (etched, scored, particulate), exposing the inner Styrofoam padding. The damaged chair surface measured approximately 4-inches-wide by 30-inches-long. Maintenance Director I indicated he would remove and replace the damaged chair as soon as possible.</p> <p>[NAME]</p> <p>Resident/Visitor Restroom: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. Maintenance Director I indicated he would have housekeeping thoroughly clean and sanitize the soiled grill assembly as soon as possible.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Service Corridor</p> <p>Staff/Shower Room: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. Maintenance Director I indicated he would have housekeeping thoroughly clean and sanitize the soiled grill assembly as soon as possible.</p> <p>Kitchen Storage Room: The atmospheric vacuum breaker was observed broken (missing bonnet) on the mop sink faucet assembly. Maintenance Director I indicated he would have staff replace the faulty atmospheric vacuum breaker as soon as possible.</p> <p>On 04/16/25 at 01:30 P.M., An environmental tour of sampled resident rooms was conducted with Maintenance Director I. The following items were noted:</p> <p>122: The restroom return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits. The maroon vinyl covered recliner was also observed (etched, scored, particulate), adjacent to Bed 1. The damaged headrest surface area measured approximately 12-inches-wide by 30-inches-long. The damaged armrest surface area measured approximately 3-inches-wide by 6-inches-long, along each armrest section. Maintenance Director I indicated he would have staff remove and replace the damaged recliner chair as soon as possible. Maintenance Director I also indicated he would have housekeeping thoroughly clean and sanitize the soiled grill assembly as soon as possible.</p> <p>135: The shower wand assembly was observed missing an atmospheric vacuum breaker. Maintenance Director I indicated he would have staff install an atmospheric vacuum breaker on the shower wand assembly as soon as possible.</p> <p>142: The shower wand assembly was observed missing an atmospheric vacuum breaker. Maintenance Director I indicated he would have staff install an atmospheric vacuum breaker on the shower wand assembly as soon as possible.</p> <p>218: The shower wand assembly was observed missing an atmospheric vacuum breaker. Maintenance Director I indicated he would have staff install an atmospheric vacuum breaker on the shower wand assembly as soon as possible.</p> <p>224: The maroon-colored vinyl recliner chair was observed (etched, scored, particulate), exposing the inner Styrofoam padding. The damaged headrest surface measured approximately 12-inches-wide by 30-inches-long. Maintenance Director I indicated he would have staff remove and replace the damaged recliner chair as soon as possible.</p> <p>232: The restroom return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. Maintenance Director I indicated he would have housekeeping thoroughly clean and sanitize the soiled grill assembly as soon as possible.</p> <p>246: The maroon-colored vinyl recliner chair was observed (etched, scored, particulate), exposing the inner Styrofoam padding. The damaged headrest surface measured approximately 12-inches-wide by 30-inches-long. Maintenance Director I indicated he would have staff remove and replace the damaged recliner chair as soon as possible.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/16/25 at 03:15 P.M., An interview was conducted with Maintenance Director I regarding the facility maintenance work order system. Maintenance Director I stated: We have the TELS system.</p> <p>On 04/17/25 at 09:30 A.M., Record review of the Policy/Procedure entitled: Maintenance Department dated 09/19/2024 revealed under Policy: To assure proper maintenance of the physical plant. Record review of the Policy/Procedure entitled: Maintenance Department dated 09/19/2024 further revealed under (IV) General Facility Maintenance: The department will do on-going monitoring of the facility for areas needing repair and, if needed, will report to the supervisor for approval of the repairs needed.</p> <p>On 04/17/25 at 09:30 A.M., Record review of the Policy/Procedure entitled: Housekeeping Services dated 02/28/25 revealed under Policy: To promote a sanitary environment. Record review of the Policy/Procedure entitled: Housekeeping Services dated 02/28/25 further revealed under (I) Frictional Cleaning: (A) Thorough scrubbing will be used for all environmental surfaces that are being cleaned in resident care areas.</p> <p>On 04/17/25 at 09:45 A.M., Record review of the Direct Supply TELS Work Orders for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.</p>		