

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Regency at Grand Blanc		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 Grand Pointe Court Grand Blanc, MI 48439	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348</p> <p>This citation pertains to Intakes Numbers MI00151425 and MI00151742.</p> <p>Past Non-Compliance (PNC) was identified at the facility during the investigation of the allegation and was accepted by the survey team upon exit from the facility for this citation. Following discussion with the State Manager, Past Non-Compliance was accepted with a Compliance Date of 3/28/2025.</p> <p>Based on the interview and record review, the facility failed to immediately notify the emergency contact regarding the resident's change in condition, which resulted in hospitalization for one resident (R#302) and delayed notification for one resident (R#301) after a fall of six residents reviewed for notification of changes.</p> <p>Findings include:</p> <p>Resident #301 (R301):</p> <p>A review of Resident #301's medical record conducted on 4/16/25 at 3:30 PM revealed Resident #301 (R301) was [AGE] years old and admitted to the facility on [DATE], with a diagnosis of Dysphagia, Malignant Neoplasm of the Bronchus or Lung, and Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left non-dominant side in addition to other diagnoses. While at the facility, he had multiple falls on 2/14/25, 2/25/25 and 2/26/25. R301's Brief Interview for Mental Status (BIMS) was 12/15 assessed on 2/9/2025. A score of 12 indicates moderate cognitive impairment. Scores between 8 and 12 are generally classified as indicating a need for additional assistance with daily activities and or specific tasks, suggesting cognitive decline. Section GG of the Minimum Data Set (MDS), dated [DATE], was not completed to show the required assistance with Activities of Daily Living. However, Section H was coded for frequent incontinence for Bladder (urinary Elimination Pattern and a was coded 9 for bowel continence, which indicated that R301 had an ostomy or did not have a bowel movement for the entire 7 days.</p> <p>A review of the R301 fall incident report on 2/25/25 at 0740 AM indicated that the incident occurred at 0740 A. However, the physician was notified of the fall at 17:30 (5:30 PM), and the family was notified at 1740. The family reported a delay in informing the family/responsible party.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A late entry was noted in R301's Nurses Notes dated 2/25/25 at 17:40. It was pointed out that Per Nurse on duty at the above date and time Guest was observed laying on the left side on the floor between the bed and window. The fall was unwitnessed. R301 was described as confused at the time of the fall but denied hitting his head or being in pain. He had aggravated areas on the left lower leg, requiring a dressing.</p> <p>In the Late Entry nurse notes dated 2/25/25 at 17:40, the nurse did not indicate when the fall occurred. Still, the Incident/accident report and post-Fall Report stated 07:40. The Physician, however, was noted to have been notified at 1730, and the son/responsible party was notified at 17:40 (5:40 PM). The responsible party was notified 10 hours after the fall occurred.</p> <p>Another Late Entry dated 2/25/25 was a nurse note scratched out due to incomplete documentation.</p> <p>The author of the 2 (two) Late Entry nurses' notes was not identified, so further verification of the accuracy of the documentation and incident was limited. The surveyor on 4/16/25 at 3:30 PM, could not verify whether the emergency contact was contacted or whether an attempt to contact the emergency contact occurred.</p> <p>Resident #302 (R302):</p> <p>A review of R302's Electronic Medical Record revealed that R302 was [AGE] years old and admitted to the facility on 2//6/2025 with a diagnosis of Acute Chronic systolic (Congestive) Heart Failure, Acute Pulmonary Edema, Pleural Effusion, weakness, and history of Falling in addition to other diagnoses R302 listed her son as the Emergency Contact #1. The Minimum Data Set MDS, dated [DATE], revealed a brief interview for mental status BIMS with a score of 12/15. A score of 12 indicates moderate cognitive impairment. Scores between 8 and 12 are generally classified as indicating a need for additional assistance with daily activities and or specific tasks, suggesting cognitive decline.</p> <p>The resident's son, who was the designated emergency contact, reported on 4/15/25 at 10:30 AM via phone that he was not notified that his mother was at the hospital. He discovered when he visited his mother and was told she was sent to the hospital and was getting surgery. R302 sustained multiple fractures. The son did not receive a call from the facility, and if he did not visit his mother, he would not have known.</p> <p>An interview with Nurse F was conducted on 4/15/25 at 4:00 PM; she revealed that she was there to help another nurse when they noticed R302's change in mental status. R302 could not remember her nurses and caregivers and could be confused about where she was. She complained of pain in the left shoulder. We referred R302 to be seen by the nurse practitioner NP for evaluation. R302 was immediately sent to the nearby hospital. Nurse F was asked if she had notified R301's son regarding the apparent change in condition and hospital transfer. She said no because a different nurse was assigned when R301 was transferred to the hospital.</p> <p>The nurse responsible for R302 was not at the facility on 4/15/25 at 4:15 PM.</p> <p>The administrator indicated on 4/16/25 at 3:00 PM that they would like to submit the past Non-Compliance related to the R302 incident and that their compliance date was 3/28/25.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to Nurse Practitioner A on 4/17/25 at 10:25 AM, revealed that the nurses called the responsible party for changes in condition, fall, or transfer. She did not call to notify the resident's family,</p> <p>Past Non-Compliance:</p> <p>A review of the facility documentation titled Facility Past Non-compliance/QAPI Plan Family Notification</p> <p>The date of the Report was 03/25/25.</p> <p>Checklist revealed the following:</p> <p>Description of Deficient Practice (why and how did it happen): On 3/21/25, 1st shift nurse noted a significant change in mental status for R302 (Resident's name mentioned), who no longer knew her caregivers and believed she was in the hospital. Staff also noted ongoing complaints and guarding her left shoulder. Of note, R302 (name mentioned) did have a fall from the edge of the bed on 3/19/25; staff monitored the left arm r/t c/o pain. Full ROM was noted at the time of the incident, and the X-ray was notified via the Unit Manager. Staff failed to accurately reflect the communication of this info to R302's emergency contact. Emergency contact states they did not receive information regarding transfer to the hospital.</p> <p>Plan of Correction: Like residents are identified as any residents residing in the facility that experiences a change of condition &/or transfer out of facility.</p> <p>Corrective action taken for the Resident affected:</p> <p>Resident transferred out to hospital 3/21. Emergency contact in the facility and spoke with weekend Nurse Manager regarding transfer.</p> <p>Measures or Systemic changes made to ensure deficient practice was corrected will not recur. Responsible nurse will make contact with emergency contact and update them on patient info; including a coc/transfer; including from an outpatient appt or dialysis. This Task will not be delegated to another for completion. All licensed nurses were re-educated on the requirements for reporting a change in condition/transfer to emergency contact.</p> <p>How facility monitors its corrective actions to ensure deficient practice was corrected and will not recur. The Director of Nursing/Designee will audit residents with coc/hospital transfer weekly X 4 then monthly X 2 months to appropriate contact was made. Findings will be reviewed by the QAPI committee monthly for 3 months for further recommendations. Any area of non-compliance will be addressed.</p> <p>The date of completion of Past Non-Compliance was dated 03/28/2025.</p> <p>The State Surveyor verified the documentation provided by the facility and conducted interviews with facility staff. During the interviews, staff reported that they had been educated on the facility's policy for abuse, including reporting abuse, and were knowledgeable about the facility's policies.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348</p> <p>This Citation pertains to Intake Number MI00150768.</p> <p>Based on interviews and record review, the facility failed to ensure appropriate wound treatment, assess, monitor, and establish a care plan for one resident (Resident #301), who sustained a laceration on the left lower extremity after a fall, of three sampled residents reviewed for skin care treatments.</p> <p>Findings include:</p> <p>Resident #301 (R301):</p> <p>According to the review of Electronic Medical Records (EMR) conducted on 4/16/25 at 3:30 PM, R301 was [AGE] years old and admitted to the facility on [DATE], with a diagnosis of Dysphagia, Malignant Neoplasm of the Bronchus or Lung, and Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left non-dominant side in addition to other diagnoses. While at the facility, he had multiple falls on 2/14/25, 2/25/25 and 2/26/25. R301's Brief Interview for Mental Status (BIMS) was 12/15 assessed on 2/9/2025. A score of 12 indicates moderate cognitive impairment. Scores between 8 and 12 are generally classified as indicating a need for additional assistance with daily activities and or specific tasks, suggesting cognitive decline. Section GG of the Minimum Data Set (MDS), dated [DATE], was not completed to show the required assistance with Activities of Daily Living. However, Section H was coded for frequent incontinence for Bladder (urinary Elimination Pattern and a was coded 9 for bowel continence which indicated that R301 had an ostomy or did not have a bowel movement for the entire 7 days.</p> <p>A review of the progress notes conducted on 4/17/25 at 10:00 AM, according to the Nurse Practitioner A (NP A), revealed that R301 was examined by the NP A dated 2/25/25, In the Progress note, the time of the NP visit was specified as 0:00. According to the progress note dated 2/25/25 at 0:00, noted that in the findings, A wrote: S81. 802A- Unspecified open wound, left lower leg, initial encounter: He had a laceration in the left lower lateral leg. No further bleeding was noted. Continue open to air. Monitor the patient.</p> <p>An interview with the Nurse Practitioner A (NP A) was conducted on 4/17/25 at 10:30 AM. According to NP A, R301 had a Fall on 2/24/25; he denied trauma and denies hitting their head during the fall. R301 did not mention how he hurt his left leg. NP A described that on February 25, 2025, during a regular visit, R301 told the story about the laceration and the bruise on the leg. There was obvious blood observed on the sheet. When asked what happened, R301 explained that it was from the bed, that he had scratched his left leg, and that he had scabbed over it. NP A ordered for the laceration to be air-dried and to be monitored for bleeding because he was at risk for bleeding. R301 was taking medication Apixaban, a blood thinner. The medication is a blood thinner, so it may take longer than usual to stop bleeding. If you cut or injure, that could cause internal bleeding or bruising. On February 26, 2025, R301 had the 3rd fall and was found on the floor. NP A stated, The leg was ok upon discharge.</p> <p>A review of R301's EMR was conducted on 4/17/25 at 1:30 PM. Here are the findings:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Treatment Administration Record (TAR) did not show any assessment regarding the Left Lower Extremity scabbed area or bleeding. No order was entered for scabbed area monitoring or treatment of the left leg in the TAR, and no monitoring was found as an order.</p> <p>Nurse Progress Notes dated 2/25/25 at 1740 wrote a Late Entry- Per nurse on duty . guest (referring to R301) observed laying on the left side on the floor between bed and window. He aggravated areas on the left lower leg from rubbing at night. The dressing was applied to stop the guest from rubbing his leg . The TAR showed no (daily or frequent) monitoring specifically for the left lower leg starting on 2/25/25 as recommended by NP'A, and no care plan was in place for R301's left lower leg.</p> <p>Nurses Progress Notes dated 2/26/25 at 10:10 AM noted: .Left Leg monitored a xeroform dressing continue to apply to protect the skin. No details of the skin characteristics: length, width, depth, nor if the area was swollen, discolored (bruised or had any bleeding or discharges.</p> <p>Nurses Progress Notes dated 2/27/25 at 11:15 AM noted: Guest (referring to R301) c/o about pain in his arm but pointing to his leg . No further details were noted.</p> <p>Nurses Progress Notes dated 2/28/25 at 00:58 Total Body Skin Assessment. Noted: . Number of new skin conditions: 0</p> <p>On 4/17/25 at 1:30 PM, a review of the Post Discharge Plan and Summary signed by nursing staff on 3/1/2025 indicated. VII. #29 Skin Condition at the time of discharge: No entry (Left Blank). #30. Post Discharge Care for Skin Conditions: apply an antifungal cream to the groin area twice daily until the clean left leg wound is with N/S (Normal Saline), apply Xeroform, and wrap in kerlix.</p> <p>According to WoundSource.com, A xeroform dressing is intended for use as a primary contact layer in dressing wounds such as lacerations, skin graft recipient sites, newly sutured wounds, abrasions, and minor or partial thickness burns .It contains a 3% Bismuth Tribromophenate solution, which has bacteriostatic properties. Used in deep or shallow wounds, non-adherent to reduce trauma to the wound and patient upon removal.</p> <p>R301's Fall record dated 2/14/25 was reviewed on 4/16/25 at 3:45 PM. R301 fell and landed on the floor. The Incident and Accident (I/A) report indicated a red mark on the left side of his face, and the nurse documented an abrasion to the left lower extremity.</p> <p>Unit Nurse Manager D was interviewed on 4/17/25 at 1:10 PM. She explained that the resident had multiple falls for the short time he stayed at the facility. The first fall- Fall#1 was on 2/14/25. R301 did not receive any treatment prior to 2/25/25. His second fall was on 2/25/25. Another fall (Fall#2) occurred on 2/26/25 where R301 slid off the bed. There was no mention of any injuries. No treatment was indicated. The third fall (Fall #3), R301, fell again on 2/26/25, and that is when his left leg was aggravated. Treatment started after the 2/25/25 fall. The unit manager, D, stated that the left leg had a treatment order: clean it with NS (Normal saline), apply Xeroform, and wrap it daily until it is healed. An order to monitor until healed.</p> <p>The Treatment Administration Record for February 2025 for R301 was reviewed on 4/17/2025 at 1:20 PM. No orders pertaining to the Left lower extremity were found.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility Policy entitled Skin Management, last revised on 8/14/2024, was reviewed on 4/17/25 at 4:05 PM. According to the facility policy's overview, Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated, and given appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes.</p> <p>Practice Guidelines:</p> <p>. 6. The interdisciplinary team considers whether the resident exhibits conditions, or is receiving treatments, that may place the resident at higher risk of developing pressure injury or complicate their treatment. Such conditions may include:</p> <ul style="list-style-type: none"> o Cognitive impairments o Drugs such as steroids that may affect wound healing o Impaired/decreased mobility and decreased functional ability o Co-morbid conditions, such as end-stage renal disease, thyroid disease, or diabetes mellitus o Impaired, diffuse or localized blood flow: for example, generalized atherosclerosis or lower extremity arterial or peripheral insufficiency o Bowel and/or bladder incontinence o Abnormal labs, malnutrition, hydration deficits. Resident Refusal of some aspect of care and/or treatment . <p>.9. The licensed nurse will monitor, evaluate and document changes regarding skin condition (to include: dressing, surrounding skin, possible complications and pain) in the medical record.</p> <p>.12. If a new area of skin impairment is identified, notify the resident, responsible party, practitioner, DON/designee, and treatment team, if applicable .</p> <p>Treatment of Skin Tears</p> <p>A skin tear is an opening or break in the skin due to friction, shear, or trauma and is technically a separation of the epidermis and dermis. All skin tears will be evaluated, documented, and treated based on the physician's orders.</p> <p>Guidelines:</p> <ol style="list-style-type: none"> 1. Upon occurrence, all skin tears will be reported to the licensed nurse. 2. An Incident and Accident Report is to be completed. 3. The licensed nurse is responsible for documenting skin tears upon occurrence and monitoring them weekly until healed. Skin Management. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Notify the practitioner and responsible party of the occurrence, document the notification in the medical record, and initiate an order as needed.</p> <p>5. Photos of skin tears are not required.</p> <p>Bruises</p> <p>1. An Incident and Accident report is to be completed.</p> <p>2. The licensed nurse is responsible for documenting bruises upon occurrence and monitoring until healed.</p> <p>3. Notify the practitioner and responsible party of the occurrence, document the notification in the medical record, and initiate an order as needed.</p> <p>4. Photos of bruises are not required.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348</p> <p>Refer to Intake Numbers: MI00151742</p> <p>Based on observation, interview, and record review, the facility failed to: 1.) provide services to prevent the development of new pressure ulcers consistent with professional standards, 2.) provide the appropriate skin care interventions to promote healing for two sampled residents (R304 and R306) of five residents reviewed with pressure ulcers, resulting in the development of avoidable pressure ulcer, delay in treatment and healing and potential for wound infection, pain, and complications.</p> <p>Findings include:</p> <p>Resident# 304 (R304)</p> <p>During the initial interview on 4/16/25 at 1:56 PM, R304 revealed he had recently developed a wound at the facility and stated he was not turned by staff as frequently as he should have been.</p> <p>According to the Record review conducted on 4/16/25 at 3:30 PM, R304 was [AGE] years old and admitted to the facility on [DATE] with the diagnosis of spinal stenosis at the lumbar region without neurogenic claudication and had surgical fusion of the spine (cervical region) procedure recently, anxiety disorder, neuromuscular dysfunction of the Bladder, and diabetes mellitus in addition to other diagnoses. R304 was admitted with an indwelling catheter for urinary retention upon discharge from the hospital. R304's Brief Interview for Mental Status (BIMS) score assessed on April 4, 2025, was 15/15. A score of 15 means R 304 is cognitively intact. R304 depended on staff for most Activities of Daily Living (ADL) tasks, especially toileting, hygiene, and showers. R304 had a urinary indwelling catheter but was always incontinent with a bowel elimination pattern. Minimum Data Set, dated dated dated [DATE] in Section M- (Skin Conditions) revealed R304 was at risk for developing Pressure ulcers and Injuries. Although R304 had a post-surgical wound from a recent spinal fusion procedure, there were no assessment upon admission that indicated skin injuries or alterations in skin integrity related to pressure ulcers or Moisture Associated Skin Damage (MASD) during admission and the initial skin assessment performed on April 4, 2025.</p> <p>A review of the facility's Admission Skin assessment dated [DATE] noted no new wounds. However, according to the nursing progress notes dated 4/14.2025 at 15:54 (3:54 PM), it revealed, Wounds on Buttocks. Present on Bilateral cheeks. Under notes, revealed: Guest with new pressure areas to B/L (bilateral) buttocks. Wound beds are beefy red, scant drainage present, no slough or necrosis or s/s (signs and symptoms of infection) . The Education box specifically noted the : Importance of frequent turning and repositioning for pressure relief. Allow staff to provide incontinence care as needed.</p> <p>A follow-up neuro-surgical consultation report dated 4/10/25 was reviewed on 4/17/25 at 2:12 PM. Surgeon's Report indicated: . I also recommend the patient keep moving frequently at least every hour to prevent bed sores .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>No showers were recorded or documented from admitted d 3/31/25 until 4/7/25, a week after admission. R304 refused shower on 4/7/25, No record of skin assessment nor redness, discoloration or abnormality was noted until the Nurse's Wound assessment dated [DATE] described new wounds found on the bilateral buttocks.</p> <p>An interview with the wound nurse in the R304 unit was conducted on 3/17/25 at 1:00 PM. The Wound Nurse indicated that R304 was admitted to the facility on [DATE] without pressure wounds and developed them in-house. R304 had a hard time moving due to pain and does not get out of bed too often. The wound nurse recalled receiving a referral on 4/15/25 with the following wound measurements on the Sacrum: Area: 17.02 cm, 4.07 cm L (length), 8.22 cm W (width), 0.1 cm D (depth). According to the Wound Nurse, a treatment plan for R304 has started. The wound mattress and roho cushion on the wheelchair were ordered on 4/15/25 and added to R304's wound care plan. The pressure wound mattress was implemented on 4/15/25. R304 received encouragement and is turned more often.</p> <p>During wound care observation on 4/17/25 at 2:40 PM, the unit nurse manager and the unit wound nurse provided wound care to R304. R304's wife/POA was present at the bedside. R304 had an indwelling urinary catheter in place. After the wound dressing was applied, R304 denied pain and described the discomfort as stinging when the wound treatment was applied. The wound area was very red and tender. The wound measurements were consistent with the current wound measurement documented on 4/15/25: Area: 17.02 cm, 4.07 cm L (length), 8.22 cm W (width), 0.1 cm D (depth).</p> <p>A review of R304's Risk for Impaired Skin Integrity/ Pressure Injury Care Plan was created on 3/31/25; turning and repositioning, off-loading, and frequent skin assessment were not implemented as preventive measures upon admission. The wound nurse created the preventive measures and interventions to avoid the development of pressure ulcers, such as turning/repositioning the resident every 2 hours and PRN on 4/15/25 after a new pressure injury developed. The wound evaluation and treatment plan of care started on 4/15/25.</p> <p>Resident# 306 (R306)</p> <p>R306 was interviewed on 4/16/25 at 3:12 PM, R306's son was in the room with her. R306 revealed having issues with wound care. R306 had indicated that she started out with one small pressure area when she was first admitted ; now, there are two, and they have become bigger. She had other wounds on her bilateral legs that was infected and needed treatment and attention, however, her buttocks wound area expanded. R306's son had indicated that they had requested a pressure wound bed upon admission because it seemed to work at the hospital for all her wounds (both legs and her back), but the facility did not have them until they noted that the wound area became larger. The son indicated that R306 was not frequently checked by staff, and it took 6 days before they changed the dressing for her wounds on the legs.</p> <p>A record review of R306's Electronic Medical Record EMR revealed that R306 was admitted to the facility on [DATE] with the diagnosis of Diabetes Mellitus, Acute Kidney Failure, Cellulitis of the right and left lower limb, and Neuromuscular dysfunction of the Bladder. On 4/16/265 at 3:18 PM, R306 was observed with a patent urinary indwelling catheter in place on 4/16/25 at 3:12 PM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Regency at Grand Blanc		STREET ADDRESS, CITY, STATE, ZIP CODE 1330 Grand Pointe Court Grand Blanc, MI 48439	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Unit Wound Nurse was interviewed on 4/17/25 at 12:37 PM. She revealed that R306 received treatment for bilateral venous wounds on both lower extremities upon admission. R306 was admitted on [DATE]. She is a dialysis patient and has a compromised skin. She did not have anything when she was first admitted except for a shearing noted on the left buttocks. It was first pointed out on 4/6/25 with a baseline measurement of: Area 3.6 cm, 2.72 cm (L), 2.25 cm (W) with a depth of 0.1 cm. On 4/15/25, the left buttocks measurement revealed the following: Area: 4.09 cm, 4.64 cm (L), 1.88 cm (W). A new wound was found on the Right Buttocks, measured: Area: 2.6 cm, 2.4 cm (L), 1.7 cm (W). On 4/15, there are currently two wound areas being treated.</p> <p>During wound care observation was performed by the Wound Nurse and the Unit Nurse Manager on 4/17/25 at 11:53 AM; R306 had an indwelling urinary catheter noted in place. Redness was observed on the right and left gluteal wound, and skin irritation surrounding the perineal area. The Unit Nurse Manager explained that the irritated and reddened area was from a loose bowel movement. R306 was also observed with the swollen right big toe pressure ulcer with a black spot in the middle of the reddened, swollen area. No drainage nor open wound. When the wound nurse was queried, she stated that a dark discoloration on the tip of the right big toe was considered unstageable. It was just a recently developed house found on Tuesday, 4/15/25. The measurement was consistent with the recent wound description: Area=0.84 cm, .92 cm (L) with 1.25 cm (W).</p> <p>A review of R306 Risk for Impaired Skin Integrity/Pressure Injury Care Plan indicated that it was initiated/created on 4/5/25 with a revision date noted on 4/17/25. After reviewing the plan of care and interventions, no new interventions were put in place after newly developed wounds were discovered on 4/15/25. No specific revisions or added care interventions for staff were put in place to prevent the development or worsening of wounds. No new interventions were added for th right big toe new pressure area.</p> <p>The Facility Skin Management Policy with a revised date on 8/14 2024 was reviewed on 4/17/25 at 4:05 PM:</p> <p>Policy</p> <p>The facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries.</p> <p>Overview</p> <p>Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes.</p> <p>Practice Guidelines:</p> <p>.3. Appropriate preventative measures will be implemented on residents identified at risk and the interventions are documented on the care plan.</p> <p>4. Residents admitted with any skin impairment will have: o Appropriate interventions implemented to promote healing, o A physician's order for treatment, and o Skin impairment location, measurements and characteristics documented</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>5. The licensed nurse will initiate documentation in the electronic health record, which includes a description of the skin impairment as follows: o In Electronic Health Record (EHR) facilities, the licensed nurse will document on the skin and wound evaluation for pressure injury and vascular ulcers. o Document weekly until the area is resolved. o Photos may be taken of pressure injury and vascular ulcers skin and wound evaluation for pressure injury and vascular ulcers. o Document weekly until the area is resolved. o Photos may be taken of pressure injury and vascular ulcers</p> <p>6. The interdisciplinary team considers whether the resident exhibits conditions, or is receiving treatments, that may place the resident at higher risk of developing pressure injury or complicate their treatment. Such conditions may include: o Cognitive impairments o Drugs such as steroids that may affect wound healing o Impaired/decreased mobility and decreased functional ability o Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus o Impaired, diffuse or localized blood flow: for example, generalized atherosclerosis or lower extremity arterial or peripheral insufficiency o Bowel and/or bladder incontinence o Abnormal labs, malnutrition, hydration deficits o Resident refusal of some aspect of care and/or treatment o A history of a healed pressure injury</p> <p>7. An initial care plan is developed upon admission/readmission if the resident is at risk or has a pressure injury and the comprehensive care plan may address: o Identifying the contributing risk factors for breakdown, including history of skin impairment or actual impairment o Hydration o Nutrition o Preventative devices, including recumbent and seated support surfaces o Preventative skin care o Pain o Physical activity o Positioning requirements o Proper body alignment o Education - when appropriate</p> <p>8. The licensed nurse will document preventative measures on the care plan/kardex.</p> <p>9. The licensed nurse will monitor, evaluate and document changes regarding skin condition (to include: dressing, surrounding skin, possible complications and pain) in the medical record .</p>		