STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235666	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Grand Blanc	1330 Grand Pointe CT 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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2697789.Based on observation, interview and record review the facility failed to complete thorough respiratory assessments for one resident (Resident #1) and establish a completed oxygen order for one resident (Resident #2). Findings Include:Resident #1:On 1/2/2026 at approximately 12:20 PM, an interview was conducted with Resident #1's daughter. She stated her mother admitted to the facility for strengthening after she fractured her tibia and fibula, while at the facility it was discovered she had pneumonia and utilized oxygen daily. Concern was expressed that as Resident #1's time at the facility progressed, she required increased oxygen supplementation. In addition, the two antibiotic courses did not appear to be effectively treating her pneumonia. When Resident #1 began the second antibiotic the facility was unable to get her breathing under control and her oxygen was consistently being increased to 4 Liters or higher. She stated they believe there was delay in the facility transferring Resident #1 to the hospital for further evaluation and treatment. On 1/2/2026 at approximately 1:30 PM, a review was conducted of Resident #1's medical records and it revealed she admitted to the facility on [DATE] with diagnoses that included, displaced fracture of left lower leg, Acute Respiratory Failure, Depression, Diabetes and Atrial Fibrillation. Resident #1 required the assistance of staff for some of her daily care but was cognitively intact and able to make her needs known. Further review yielded the following:Radiology Results:11/13/2025: .There is modest infiltrate in the right upper lobe. The osseous are unremarkable. Modest right upper lobe infiltrate.11/28/25: .There is interval worsening of the right mid upper lung opacities as well as left apical opacites.Worsening bilateral opacities concerning for pneumonia. Progress Notes:11/11/2025 at 18:27: Guest has been admitted from (hospital) for fall.Guest has ace wrap and immobilizer to L (left) extremity.Guest tolerates supplemental oxygen at 2L (liters) via NC (nasal cannula).11/12/2025 at 23:26: .Provider was notified of this guest requesting something for a cough, she was noted to have a occasional non-productive wet cough. Lungs are clear and diminished bilaterally, slight wheezing noted to right upper lung.11/13/2025 at 08:00: .Patient on supplemental oxygen, patient feels cough and sob (shortness of breath) is worsening.11/14/2025 at 08:00: .Patient had chest xray due to worsening cough, reviewed xray with patient.Avelox (antibiotic). labs revealed elevated WBC (White Blood Count).11/15/2025 at 22:32: Guest is currently on Avelox (Moxifloxacin) once daily for Pneumonia. Guest complaining of cough and asking if there is something we can get to help, and requested cough syrup.on-call notified of request and new order for PRN (as needed) Guaifenesin liquid 10mL (milliliters) every 6 hours ordered and guest was added for rounding to evaluate. 11/19/2025 at 08:00: .Denies any sob, reports not needing oxygen supplementation. Only needed acutely during exacerbation of respiratory issues. 11/27/2025 at 19:56: Guest vitals were taken for daily charting.BP-100/64, P-98, R-18, o2 82-88% on Room air. Guest was recently on 2-3L continuous oxygen therapy at admission via N/C.Writer checked VS again and still between 82-87% on Room air and guest c/o some SOB (shortness of breath). Writer applied 02 at 3L. (continued on next page)

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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o2 after oxygen applied and guest up to 94% on 3L of o2.11/28/25 at 08:00: .Patient was seen today for follow up of low oxygen saturation. She was lying in the bed with no acute distress. She has shortness of breath at times. Left lung is diminished. She has cough with mucus at times.11/29/2025 at 08:00: .Chest xray results follow up. Showed pneumonia, started patient on antibiotics, breathing treatments. Patient reports shortness of breath, on assessment SpO2 was 83% on room air,, placed on oxygen, lung sounds are diminished to right upper lobe. SpO2 now >92% on 2L via nasal cannula. Levofloxacin 750 mg (milligram) p.o (by mouth) once daily for 5 days. 12/2/2025 at 08:00: Nurse reports pt (patient) was ordered a chest xray due to cough and congestion, results concluded bilateral Pneumonia. Pt will be started on Levofloxacin 750 mg (milligram) tablet. 12/4/2025 at 02:00: Vitals taken at T99.1, R 36, O2 75%, BP 121/69 HR 114 Pt was pale ad tired, struggling to breathe PRN rescue inhaler given. (Oncall) notified ordered O2 increase to 5 liters, Mucinex give 400 mg and ordered another Duoneb RN Q 4hrs. After breathing tx (treatment) O2 82-84% pt still did not feel better. (on call) notified again ordered to send out to ER for eval & tx.Ambulance came picked left at 2 AM. 12/4/2025 at 08:00: Nurse reported SpO2 was 78% on 3L; increased to 4: spO2 improved to 82%. Pt currently being treated for PNA (pneumonia). Nurse reported bilateral wheezes 121/69 HR 114, temp 99.1, RR 18. Pt had breathing treatment at 2200 and prn albuterol 000. VO (verbal order) to start Mucinex 400 BID x 10days.facility stock of Mucinex is 400mg gave ok to change Mucinex to 400mgBID x 10 days. O2 at 5L SpO2 still staying 82-84%. VO for pt to be sent to ER for further eval.It can be noted nursing notes were reviewed from admission to discharge and there were minimal thorough respiratory assessments that included lung sounds. Physician Orders:Avelox Tablet 400 MG- 1 tablet by mouth one time a day for Pneumonia. Ordered on 11/14/2025 and discontinued on 11/23/2025. Levofloxacin Oral Tablet 750 MG- give one table a day for PNX (pneumonia) for 5 days. Ordered on 11/29/25.Trelegy Ellipta Inhalation Aerosol- 1 inhalation inhale orally one time a day. Ordered on 11/12/2025.Ipratropium- Albuterol Solution 0.5- 2.5 MG/3 ML- 3 ml inhale orally three times a day.evaluate HR and lung sounds pre & post treatment. If abnormal findings, document in progress notes. ordered 11/11/2025 ProAir HFA inhalation Aerosol Solution 108 (90 base) MCG/ACT (Albuterol Sulfate- 2 puff inhale orally every 6 hours as needed for shortness of breath/wheezing.Oxygen Orders:02 0.5-2L via NC to maintain spo2 >89%. Order was initially entered on 11/12/2025 and discontinued on 11/20/2025.It can be noted when Resident #1's oxygen therapy was reinstated on 11/27/2025 due to decrease in oxygen levels, the physician order for supplemental oxygen was never reentered into the medical record. Skilled Care Notes:12/2/2025 at 16:28:.Respiratory: Oxygen .12/3/2025 at 18:30: .Respiratory: None. Sepsis Screening Evaluation:12/3/2025 at 18:31The evaluation indicated Resident #1 did not have a documented infection nor was receiving antibiotic therapy.The skilled care notes and sepsis evaluation notes did not capture the full respiratory status of Resident #1. The note on 12/3/25 was inaccurate so it was unknown what the residents respiratory status was prior to 3rd shift. On 1/2/2025 at 3:55 PM, an interview was conducted with Nurse C regarding Resident #1. Nurse C shared she was assigned to provide for Resident #1 a decent amount of time and upon admission she was none weight bearing and utilizing supplemental oxygen. The resident graduated off oxygen, the boot was removed and she became stronger. Around 11/29/25 her oxygen levels were lower than usual (about 88%) and her supplemental oxygen was reinitiated, it was discovered shortly after she had bilateral pneumonia. Review was conducted of Resident #1's chart with Nurse C and it indicated Resident #1 was started on an antibiotic for pneumonia on 11/14/2025 (3 days after her admission), on 11/20/2025 her supplemental oxygen was discontinued and the 2nd antibiotic for diagnosis of bilateral pneumonia was started on 11/29/25 after Resident #1 displayed shortness of breath and low oxygen saturation levels. On 1/2/2026 at 4:50 PM, CNA (Certified (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant) D shared Resident #1 did have difficulty breathing and during her stay her supplemental oxygen was discontinued and then reinitiated. CNA D continued the resident would have shortness of breath even with her oxygen. On 1/6/2026 at 10:10 AM, Nurse K reported his shift beings at 11 PM and concludes at 7:30 AM. There was nothing that he recalls being communicated in report regarding Resident #1 that would have alerted him to check on the resident more frequently. He provided CNA J with a list of vitals to check and around 12/12:30 AM reported the residents saturation level was around 75 and heart rate at 110. Nurse K stated he went down to the room and Resident #1 was visibly pale but did not complain regarding her breathing. Upon calling the on- call provider he administered Mucinex, a beathing treatment and increased her oxygen but that was not effective as her levels only increased to about 82. Nurse K listened to her lung sounds which made a low woooo sound. On 1/7/2026 at 1:55 PM, Nurse F was interviewed regarding her care of Resident #1 on 12/3/2025. Nurse F stated typically that is not her unit and she picked up on second shift to assist from 3 PM-11:30 PM. During report she recalled being informed the residents antibiotic had not arrived from pharmacy and to pull it from backup. Additionally, 1st shift nurse reported that Resident #1, did not sound too good. The nurse was asked to clarify if the statement meant the previous nurse assessed the resident's lung sounds or from a visual assessment. Nurse F stated she was unsure as she did not ask for further clarification.Nurse F recalled administering medications without incident, holding a conversating and her vitals not being of concern. Resident #1 did not appear to be in distress nor did the resident or aides alert her to any issues with her breathing during her shift. A review was completed of the MAR and Nurse F recalled administering a breathing treatment about 9:00 PM. The nurse stated she did not assess Resident #1's lung sounds before or after the treatment was administered. Nurse F was queried if at anytime during her shift did she assess the residents lungs and she stated she did not. It is unclear based on the lack of assessment when Resident #1 began to experience a change in condition as she was not thoroughly assessed prior to third shift. On 1/7/2026 at 2:50 PM, an interview was conducted with Unit Manager H and review was conducted of Resident 1's oxygen orders. Manager H stated the resident was admitted with oxygen and it was discontinued on 11/20/25. On 11/27/25 their medical team was notified Resident #1was placed back on oxygen via nasal canula but the order was not reignited. On 1/7/2026 at 3:40 PM, an interview was conducted with Infection Preventionist I regarding Resident #1. She shared she reviewed the hospital records and found she was symptomatic (prior to admitting to the facility), and they received her chest x-ray which showed infiltrates. Her first course of antibiotics was from 11/14/25 to 11/24/25. On 11/28/2025, Resident #1 began to have onset of symptoms ranging from cough, abnormal lung examination and Sp02 </94%. The resident then began her second course of antibiotics.Preventionist I was asked what is included in lung assessment. She reported listening to the lungs and observing the resident for any outward signs of distress. A discussion was held with Preventionist I regarding the lack monitoring of Resident #1 during this time. While there was some charting it was inconsistent and failed to provide a an accurate depiction of her respiratory status. It was agreed her lung sounds would be abnormal given she had pneumonia, and the expectation would be for nurses to complete a thorough lung assessment prior to after inhaler and nebulizer treatments to ensure continued assessment throughout the infection period. ON 1/7/2026 at 4:10 PM, CNA J reported she provided care for Resident #1 frequently and during report on 12/3/2025 it was stated Resident #1 had not been feeling well and but they were aware she had pneumonia. She was maintaining a watchful eye on the resident and when she completed Resident #1's vitals, her oxygen level were in the low 80's and she informed Nurse K who requested a recheck for accuracy. The second saturation level was still in the low 80's. Resident #1 appeared to have difficulty (continued on next page)

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