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	01/22/2026

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 0658 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2710871. Based on the interview and record review, the facility failed to maintain complete, accurate, and timely clinical documentation for one resident (Resident #301) of 3 residents reviewed for accuracy and timeliness of clinical documentation. Findings include:Resident #301 (R301): According to the Electronic Medical Record review, R301 was admitted to the facility on [DATE] and expired there on [DATE]. A Medical Examiner's (ME) Report dated [DATE] revealed R301 was [AGE] years old with a past medical history consisting of a recent hip fracture with repair at the hospital (mentioned initials of the hospital), Diabetes Mellitus, Dementia, Anxiety Disorder, Coronary Angioplasty with stents, and Malignant Neoplasm of the eye in addition to other diagnoses. Due to the R30's medical history and his recent hip fracture, a suspicion of foul play was ruled out, and the cause of death was ruled a natural death. An interview with Nurse A was conducted by phone on [DATE] at 3:00 PM. She recalled working from 11:00 PM to 7:30 AM. R301 had a subcutaneous hydration that she initiated before her shift. The 3-11 shift nurse reported that the patient had shallow breathing. He looked pale, and his breathing was shallow. R301 was still breathing at around 1:00 am, as confirmed by the Nursing Assistant assigned, and at around 2:30 PM, he was found unresponsive. We overhead paged for a code and started Cardio-pulmonary Resuscitation (CPR). Nurse A admitted that she did not follow the standards of the nursing document, the time CPR started, or what the assessment was before starting CPR. She admitted that she failed to describe R301's condition as assessed: absent pulse, no blood pressure, and not breathing. She failed to note the time the staff started CPR, as well as the time the 911 ambulance arrive and took over resuscitation, and when they stopped. Nurse A stated. I did not document much. I apologize that I did not document well. I had 21 patients that night. R301 Progress Notes written by Nurse A dated [DATE] indicated: [DATE] at 3:16 AM: Note text: Guest coded at appr. 02:30, 911 alerted guest pronounced @ 0244 EMS Physician (name of physician mentioned) Hospital (name of hospital establishment written). Notified (Provider group mentioned) and daughter (name of mentioned) . DTR requesting Funeral Home in [NAME] (Business name specified). Awaiting Medical Examiner at this time.R301 Sepsis Screening Evaluation performed by Nurse B on [DATE] at 17:18 (5:18 PM) revealed:R301 Sepsis Screening EvaluationSepsis ScreeningCurrent Temperature: 98.21a. Route: tympanic [The National Institute of Health (NIH) defines tympanic temperature measurement as using an infrared thermometer to detect thermal radiation from the eardrum (tympanic membrane) in the ear canal.]Heart Rate: 89Respiratory Rate: 18Does the resident have a suspected or documented infection? (Signs of Suspected Infection: Fever, Chills, Cough, Dyspnea, Change in Sputum Character, Cellulitis, Wound Drainage, Flank Pain, Dysuria, Weakness): NoIs the resident on antibiotic therapy? NoDoes the resident have at least one of the above answered yes? NoThe above assessment was signed by Nurse B on [DATE]. Nurse B's assessment of R301 was documented on [DATE]. There was no indication of a strike-out or any late entry notification. R301's Medical Examiner and death certificate revealed R301 passed (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 0658 Level of Harm - Potential for minimal harm Residents Affected - Many	away on [DATE]. An interview with Nurse B was conducted by phone on [DATE] at 4:19 PM. She revealed that she was unaware that she made an error documenting an assessment on R301 after he had expired for a couple of days. She added that she had no access or was not allowed to do a strikeout. She further explained that: Only the managers have the strikeout option. I did not know I made an error until today. It might even be an assessment for another patient, or a late entry where I forgot to enter the actual assessment date. It happened over a month ago. I can't exactly remember what happened on that day. An interview with the Unit Manager C was conducted on [DATE] 10:52 AM. She revealed R301 had expired in the early morning of [DATE]. Nurse Manager C agreed that Nurse A should have more details in her documentation on the night R301 expired. Nurse Manager C indicated that she will review the vitals and other assessments to see if she could have documented her assessment and R301's CPR. The nurse A should have documented them in the progress notes. Besides R301's vitals, Nurse Manager C confirmed that 911 pronounced, and the Medical Examiner arrived before R301 was released to the funeral home. On [DATE], at 04:00 PM, the Director of Nursing (DON) explained:Regarding Nurse A documentation, there were no assessments recorded for R301's vitals, nor whether they initiated CPR in the documentation.However, the DON explained regarding Nurse B: Nurse B must have made a mistake in either not entering the correct date when she entered the data, or it could be for a totally different resident and not for R301. The DON further stated, We are not sure what happened. Resident #301 passed away on [DATE], and Nurse B entered the assessment on [DATE]. Facility Policy review conducted on [DATE] at 3:30 PM confirmed:Death of a Resident Policy (Last Revised on [DATE])DOCUMENTATION (page 2/2): 1. The nurse documents in the progress notes:Absence of audible/palpable blood pressure,Absence of audible/palpable heartbeat,Absence of respirations,General observations, such as degree of cyanosis or pallor, skin temperature (warm or cool), stiffness or pooling of blood in the extremities, and any other pertinent information leading to the determination of death. 2. Pronouncement of death is documented in the progress notes and must include:Who made the pronouncement.Circumstances of making the pronouncement (by telephone, in person, etc.)Date and Time of Pronouncement,Notification of family and physician,Disposition of the resident's belongings, including jewelry, dentures, glasses, and other valuable items,The date and time transported to the mortuary.Name of Mortuary transported to.Death of a Resident. Retrieved [DATE]. Official Copy at http://cienagroup.policystat.com/policy/14134778/. Copyright(C)2026 Ciena HealthcareThe second policy reviewed is entitled: Documentation Expectations Policy (Last Revised [DATE])Policy: Healthcare personnel will complete documentation requirements as outlined by the company and recorded in the medical record using accepted principles of documentation.Procedure: General: 1. Chart events as they occur and maintain chronological order. 2. The person providing the service enters the information into the medical record. Entries should not be signed by someone other than the author of the entry. 10. Entries in the Medical Record: Entries in the Medical Record should be completed in a timely manner. Entries should be made at the time of the occurrence, or as soon as possible thereafter.Charting Errors and/or Omissions:1. For electronic medical records, entry errors will be corrected per the Electronic Medical Record system utilizing the strike-out feature. 3. If it is necessary to change or add information to the resident's medical record, it shall be completed by means of an addendum. A. Write clarification or addendum and state the reason and refer to the entry being amended. B. Sign the addendum. C. Date and time stamps will occur per the Electronic Medical Record System.4. If a late entry is necessary:The new entry will be identified as a Late entry per Electronic Medical Record system standards.Enter the current date and time.Identify or refer to the date and incident/events for which the late entry is written.Complete a late entry as soon as possible, as memory of incidents/events decreases over time. Late (continued on next page)

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F 0658 Level of Harm - Potential for minimal harm Residents Affected - Many	entries should not be completed 30 days after discharge .Documentation Expectation. Retrieved [DATE]. Official copy at http://cienagroup.policystat.com/policy/13671768/. Copyright (C)2026 Ciena Healthcare