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	04/07/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement interventions to prevent falls for one resident (Resident #3) of three residents reviewed for falls, resulting in a fall from bed.Findings include:This citation pertains to intakes 2971486 and 2985660.Resident #3 (R3):R3 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include rheumatoid arthritis, morbid obesity, inability to ambulate and primary generalized osteoarthritis.On 4/6/26 at 10:30AM, record review was conducted of a fall report from 03/26/26. On 03/26/26 at 14:00PM, Certified Nursing Assistant (CNA) C was providing care to R3 without the assistance of an additional staff member. CNA C rolled R3 away from and R3 kicked her right leg over the side of the bed, causing R3 to roll from the bed on to the floor. There was bruising noted to the right knee, ice was applied, the physician, responsible party and Director of Nursing (DON) were notified of the fall. X-rays of the right knee were ordered on 3/26/26 at 17:55PM and results were received at 18:42PM and the x-ray revealed a recent impacted healing right knee fracture. The family did not want R3 sent out to the hospital and instead chose to manage the pain and keep R3 in the facility.On 4/6/26 at 10:45AM, a review of the electronic medical record (EMR) was conducted. The EMR revealed a care plan that indicated that R3 is dependent x2 staff with bed mobility.On 4/6/26 at 11:50AM, an interview was conducted with CNA C. CNA C was asked about the fall with R3. CNA C stated, I was doing peri-care, I was on the left side of the bed, I cleaned her up to change her brief, I went to the other side of the bed and pulled her towards me and she held on the rail, she is capable of holding on to the rail, then I went back to the other side of the bed and tried to finish the care, her ankles were crossed and she lifted her leg up to try and uncross them and her body weight took her over the side of the bed. CNA C stated that there had never been any issues with her (R3) being able to hold the rail, the bed was in a low position. It wasn't a big drop, but a drop, nonetheless. CNA C was asked if they should've had another staff member with them when providing care. CNA C stated, yes, I should have had another staff member with me. CNA C stated, I pulled R3 towards me so she could hold the rail like I have many times before. I received a write up, because the Kardex says she's a two-person assist with bed mobility. On 4/6/26 at 2:00PM, an interview was conducted with the DON. The DON explained the incident with R3 and the steps the facility took afterwards. The DON was asked if the CNA should have used two staff members for the care she was providing? The DON stated, yes, she should have had two people with her. We wrote CNA C up and re-educated her as well. The DON stated, we had all the CNA's and nursing staff come in and receive education on ensuring they are using the correct amount of staff assistance to complete care.Record review of the policy titled, Fall Management, revealed:Practice Guidelines:2. Residents identified at risk for fall will have an initial plan of care developed to meet each resident's needs. Interventions should be related to the risk factors as well as incorporating resident choice to help minimize the risk of a fall.On 04/6/2026 at 2:05PM, during the onsite survey, Past Non-Compliance (PNC) was cited after the facility implemented actions to correct the non-compliance which included: 1. The facility implemented interventions for the resident involved.2. An audit was completed by the unit manager/designee of residents who require the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance of two staff with bed mobility to ensure that staff are performing bed mobility with two people doing personal care.3. The facility fall process was reviewed and deemed appropriate. Education was completed with the nursing staff to ensure when we are providing care, that we review the plan of care and if it says 2-person assist for mobility, that we use two people, and when a resident requires 1-person assist, we never turn the resident away from us when performing care.4. The UM/Designee will review nursing staff, when providing personal care with residents requiring assistance with bed mobility, to ensure that staff are not turning residents away from them when performing care with 1 staff member, weekly x4 weeks and monthly x2 months. Any areas of non-compliance will be reviewed immediately. With findings submitted to the DON who will report findings to the QAPI committee for review and recommendation. The administrator will be responsible for sustaining compliance.5. Date of compliance: 04/02/2026.