STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235432	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grayling Nursing & Rehabilitation Community	331 Meadows Drive Grayling, MI 49738

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake 3009239. Based on interview and record review, the facility failed to implement and operationalize policies and procedures to ensure timely and comprehensive assessment, treatment, and documentation, per professional standards in practice, for change in condition for two Residents (#701 & #702) of three residents reviewed. This deficient practice resulted in: Delay in diagnostic testing and treatment for a Urinary Tract Infection (UTI) causing sepsis for Resident #701, and;Lack of monitoring and follow up of laboratory testing, causing Acute Kidney Injury (AKI) and need for emergency dialysis for Resident #702. Findings include:Resident #701 (R701)Review of intake documentation dated as received on [DATE] revealed a concern that R701 was admitted to the facility on [DATE] following a hospital stay. Per the intake documentation, R701 was alert when they were discharged from the hospital and started slowly getting more and more confused and declined after getting to the facility. The intake detailed R701's family requested the facility test for a Urinary Tract Infection (UTI) multiple times including on [DATE]. R701 ended up going to the ER where they became completely unresponsive and basically catatonic and passed away from Sepsis from a UTI on [DATE]st, 2025. The intake specified R701 did a 180 from the time they came to the rehabilitation facility until they left this earth.Review of requested hospital documentation revealed R701 was transferred to the ER from the facility on [DATE] and passed away in the hospital on [DATE]. Detailed review revealed the following:- [DATE] 12:47 PM: Emergency Department Report. Chief Complaint: Decrease mental status and UTI. present from (facility) for evaluation of decreased responsiveness and abnormal labs. Patient has a history of recurrent UTIs, outpatient blood work and urinalysis were performed yesterday showing worsening renal function and UTI. nonverbal on arrival and noted to be hypotensive. systolic blood pressure (top number) in the 70s. had dry mucous membranes, not responding to verbal stimuli but withdraws to painful stimuli. Suspect sepsis secondary to UTI with dehydration. Laboratory testing with worsening renal function, baseline creatinine 1.7 and up to (over) 4 (normal level per hospital lab is 0.70 to 1.30) . Blood pressure remained low despite initial IV (intravenous) fluid. Levophed (emergency vasopressor medication used short term to treat life threatening low blood pressure often seen with sepsis) started. remains in critical condition at the time of admission.- [DATE]: History and Physical. abdominal guarding/pain. Assessment/Plan: 1 Septic Shock Secondary to UTI. Presented to emergency department with. acute metabolic encephalopathy (temporary impairment of brain function caused by organ disfunction and/or imbalances in body including septic shock), hypothermia (low body temperature) . evidence of UTI. 2. UTI. 3. AKI superimposed on CKD . Secondary to septic shock and dehydration. 4. Metabolic encephalopathy secondary to sepsis. 6. Dehydration secondary sepsis and poor oral intake. Admit ICU level care for septic shock. Prognosis poor.- [DATE]: Discharge Documents: Disposition/Condition: deceased . All Diagnoses this Visit: Septic shock. UTI, Acute Kidney Injury (AKI) superimposed on CKD (Chronic Kidney Disease) . Dehydration. AKI with possible Acute Tubular Necrosis (damage to the tubules of the kidneys often resulting from lack of blood flow) due to septic shock and dehydration. Hospital Course. present to the emergency department from (facility) with mental status changes and UTI. On arrival. was profoundly ill with septic shock and (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 0684 Level of Harm - Actual harm Residents Affected - Few	acute renal failure. initially admitted to the hospital and treated. The next day had not made much clinical progress and continued to be severely ill. (Family) made the decision to transition the focus of care to comfort. passed away. on [DATE]. 8:20 AM.An interview was conducted with Family Member Witness A on [DATE] at 7:24 AM. When asked about Resident #701's care at the facility, Witness A stated, (R701) was talking and eating by themselves when they left the hospital then they went to the facility for rehab and declined. When queried what happened, Witness A verbalized R701 had a couple falls at the facility and then started to get more tired and confused. Witness A revealed they were worried R701 had a UTI. Witness A was asked if they brought their concerns up to the facility staff and responded they had. Witness A stated they spoke to a male nurse and asked them to test R701 for a UTI. When queried what happened, Witness A stated, They (male nurse) said they make a note in the chart, but they (staff) hadn't gotten it (urine sample) yet. When queried if they recalled the name of the male nurse who they had spoke to, Witness A responded they did not but they had brown hair and were well-built. Witness A was asked when they talked to the male nurse and asked about testing for a UTI and responded, It was a few days before. With further inquiry regarding the Resident's care at the facility, Witness A stated, I came and sat with (R701) every day. They never gave (R701) fresh water and they were dehydrated. Witness A continued, When I would get there at 10:00 (AM), it (R701's water) would be warm and old. I never saw them giving out water. When asked if Resident #701 needed assistance to drink, Witness A indicated they did not when they first arrived at the facility but did by the time they were sent to the hospital because they were so confused.Record review revealed R701 was admitted to the facility on [DATE] with diagnoses which included subdural hemorrhage (bleeding between the brain and the skull), CKD, anemia, and Benign Prostatic Hyperplasia (BPH- enlarged prostrate with urinary retention). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the R701 was moderately cognitively impaired and required set up to maximum assistance to complete Activities of Daily Living (ADLs). The MDS further specified R701 was frequently incontinent of both bowel and bladder and did not have a known weight loss.An interview was completed with Registered Nurse (RN) D on [DATE] at 8:35 AM. When queried if there were any well-built male nurses with brown hair who worked at the facility, RN D responded that RN E fit that description.All Incident and Accident (I and A) reports as well as any investigations pertaining to R701 were requested from the facility Administrator on [DATE] at 11:00 AM.A review of R701's Electronic Medical Record (EMR) revealed the Resident's level of alertness and orientation declined from being Alert and Oriented (A & O) X 2 to 3 (person, place and time) to being A & O X 1 -2 with confusion and A & O to self only with confusion. EMR documentation further revealed a nurses note dated [DATE] specifying nursing staff were concerned R701 had a UTI and wanted to obtain a urinalysis (UA) but a UA was not obtained until [DATE]. Documentation review further revealed inconsistencies between nursing and Health Care Provider (HCP) documentation related to mental status/confusion, nutritional status, and continence.Review of R701's documentation revealed the following:- [DATE] at 1:58 PM- Nurse Progress Note: (R701) arrived at 1:15 PM from hospital accompanied by EMS personal. A/O (Alert/Orientated) x 2-3 (person, place, time) . here for strengthening and plans to go home.- [DATE] at 12:41 PM- Social Services Note: (R701) is alert, orientated 2-3 with some occasional confusion noted. easily re-orientated.- [DATE] at 1:18 AM- Nurse Progress Note: A/Ox2 with some confusion.- [DATE] at 2:45 AM- Nurse Progress Note: (R701) is alert/oriented x 1 (self only) with confusion.- [DATE] at 1:38 AM- Nurse Progress Note: (R701). is extremely confused this shift.- [DATE] at 1:10 AM- Nurse Progress Note: (R701) is alert/oriented x 1-2 with confusion.- [DATE] at 10:36 AM- Nurse Progress Note: (R701) is to self with confusion.- [DATE] at 1:37 AM - Nurse Progress Note: (R701) is alert to self with confusion. pleasant towards staff, ability to communicate needs. was up in w/c across from nurses' desk in a high traffic area for safety concerns, once res did go to bed was talking to an imaginary man that came into room. (R701) stated to this writer ?that a random man came into building and wanted (R701) to hide something for them. Explained that no ?random man' came into room and that (R701) would need to pee into a urinal (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	so I could check urine for a UTI, but so far this evening resident has been incontinent of bladder. Note authored by RN F.- [DATE] at 2:05 PM - Nurse Progress Note: (R701) is A/O x1-2 (person, place) with periods of confusion . has a floor mat next to bed due to multiple attempts of crawling out of bed per day. Appetite remains poor.- [DATE]- Physician Note: Date of Service [DATE]. 30-Day Follow Up. evaluated today for 30-day regulatory visit. General: Positive: Fatigue, Low energy. Positive: Muscle Pain or Cramps. Negative: Confusion. Physical Exam. Positive: Well nourished, Alert, Awake. Negative: Confusion.- [DATE] at 10:49 AM - Nurse Progress Note: (R701) is alert to self only, can makes needs known. has a poor appetite.- [DATE] at 9:30 AM- Provider Note: Date of Service: [DATE].(Family) reported concerns with weight loss. Documented weight trends reveal 168.6 pounds on [DATE] and weight of 152.8 pounds on [DATE]. Intake trends reduced overall. plan was made with orders given to the Nursing staff to administer 100 mg (milligrams) megace (appetite stimulant medication) .- [DATE] - Provider Note: Date of Service: [DATE]. (R701) is being seen today for. follow up bloodwork results and reports of increased confusion. Nursing staff reports concerns with increased confusion and generalized weakness. sitting up in his wheelchair in the therapy room and appears confused today. General. Positive: Fatigue. Negative. Weight Loss. Negative. Loss of bladder control. Positive: Confusion. Negative. Weakness. Notes: Notes: Reports of increased confusion with no specific concerns or compliant from the Patient.- [DATE] at 4:51 PM- Nurse Progress Note: (R701). alert to self . appetite is poor has megace (appetite stimulant medication) ordered but still eats and drinks little. Sent a urine sample to the lab to r/o (rule out) UTI.- [DATE] at 1:06 PM- Nurse Progress Note: (R701) noted with positive UA, pending culture. shows s/s (signs/symptoms) of infection including change in mentation, decrease ADL function. (R701) condition was discussed with (Nurse Practitioner [NP] C) .- [DATE] at 4:02 PM- Nurse Progress Note: Alert and oriented x2 with some confusion. refused medications this morning, knocking the cup out of this RNs hand. is not eating or drinking much at this time.- [DATE] at 1:15 AM- Nurse Progress Note: Alert and oriented x2 (person and place) with some confusion. refused medications this evening, refused to open eyes when nurse approached. IV fluids have completed. IM (intramuscular) Rocephin for a UTI. is not eating or drinking much at this time.- [DATE] at 9:33 AM- Provider Note: DON (Director of Nursing) reported . (R701) is still not self, swatting at the wall, swatting at staff and not taking in anything orally. Despite IV fluids and initiation of Rocephin (antibiotic), condition remains as confused/AMS (Altered Mental Status) . send the Patient into the ER.- [DATE] at 9:53 AM: INTERACT Nursing Home to Hospital Transfer Form. Send to Hospital for evaluation. Reason for Transfer - infection. How long has (R701) had illness? 2 days.- [DATE] at 10:00 AM- Nurse Progress Note: (R701) has not responded to the normal saline IV and antibiotic medication that was given yesterday. send the resident via EMS to the hospital for evaluation. BP was low 96/50, resp. 22 (elevated- normal 16-20) . mouth breathing and reaching for things in the air. will not drink nor allow RN to swab mouth for moisture. CNA (Certified Nursing Assistant) notified RN (Registered Nurse) that (R701) has not voided in over 8 hours.An interview was completed with RN E on [DATE] at 1:40 PM. When queried, RN E indicated they vaguely recalled R701. RN E was asked what color hair they have and replied, Brown-ish black. When asked if they remembered speaking to R701's spouse, RN E revealed they recalled them being at the facility often. RN E was then asked if R701's spouse had discussed concerns related to R701 having increased confusion and wanting to get a UA and replied, I do not recall.A review of laboratory testing results in R701's EMR revealed the following:- A UA collected and resulted on [DATE]. The UA was positive for infection and showed the Resident's urine was dark yellow in color, cloudy, with mucous, protein bacteria, blood, Leukocyte Esterase (enzyme released by [NAME] Blood Cells [WBCs] indicating infection or inflammation), 130 WBCs (normal- 0-4), and WBC clumps. Culture and sensitivity (C&S) testing was completed by the laboratory. The preliminary C&S report was dated [DATE] and the final report was dated [DATE]. Both showed R701's urine was positive for Klebsiella pneumoniae (bacteria normally found in stool which can cause severe infections, including UTIs, and can be difficult to treat with antibiotics) and Enterobacter cloacae complex (bacteria found in the gut (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and both verbalized they did not have policies/procedures for assessment and/or documentation. When asked how nurses know what their responsibilities are in regard to what and where to document, the DON responded, We have a facility list for specific classifications which includes daily charting guidelines and who needs to be charted on for the day. The DON was asked what they meant and revealed they were referring to what residents require skin assessments on what days and/or if a resident needs post fall documentation completed. When queried about what small, medium, and large means in relation to urine output, both the DON and Administrator responded that size is documented for bowel movements, not urine output. R701's urine output documentation was reviewed, and the Administrator and DON were asked what the sizes meant and both stated they did not know. The DON verbalized they would look. A policy/procedure related to output monitoring/assessment and change in resident condition was requested at this time.An interview was conducted with CNA G on [DATE] at 9:13 AM. When queried regarding facility policy/procedure for documentation of urinary output for incontinent residents, CNA G replied, There is an area for small, medium, and large for urine output. CNA G was asked if they receive training on what constitutes the amount of urine when they document small, medium, or large, CNA G revealed they do not. CNA G then stated, That is how it has always been. I've been here 10 years. When queried if there is a reference they can look at to know what small, medium, or large urinary output is, CNA G replied, I don't think there is a reference. When asked if there is a place they can go to find answers if they are not sure about something, like a policy/procedure book, CNA G stated, I don't know if they have anything like that. CNA G was asked if they document each time a resident is incontinent and replied, No. When asked how they document the amount of urine, CNA G stated, Large is several soaked, medium is like wet but not soaked and small is like a little.A follow up interview was completed with the DON on [DATE] at 9:44 AM. When queried regarding a policy/procedure related to output monitoring/assessment, the DON stated, We don't have a policy/procedure. With further inquiry regarding the accuracy of the documentation, the DON stated, It is subjective. When queried if staff are supposed to document each episode of urinary incontinence separately, the DON did not provide an explanation. The DON then stated that the facility goes above and beyond with documentation of urinary output.On [DATE] at 11:05 AM, an interview and review of the note dated [DATE] at 1:37 AM was completed with the DON. When queried regarding the note indicating R701 would have a UA completed due to a change in mentation, the DON stated, I don't think it was ever done. When asked if increased confusion and hallucinations would be a reason to complete a UA, the DON verbalized it was. When asked if that change in condition should have been addressed, the DON stated, Yes, it should have been passed along. The DON stated, I will look through the chart and see if I have anything. When queried regarding the EMR documentation of urine output as small, medium, and large, the DON was unable to provide an explanation and/or definition of the terms. A policy/procedure related to urinary output and documentation was requested at this time.An interview was completed with CNA H on [DATE] at 11:15 AM. When queried regarding documentation of urine output in the EMR for incontinent residents, CNA H responded they document small, medium, or large. When asked what that means, CNA H replied, When we go to change them. A little is small, flooded is large, and wet is medium. CNA H was asked what flooded means and replied, On the verge of soaking through their brief. When asked if they document each soiled brief individually in the EMR, CNA H responded they do.A follow-up interview was conducted with the DON on [DATE] at 11:27 AM. The DON confirmed a UA was not completed on [DATE]. When asked why a UA was not completed, the DON stated, (Physician B) saw (R701) on the 25th and charted negative for urinary symptoms and negative for confusion. When queried regarding nursing documentation specifying the Resident was confused and disorientated, the DON replied, At night. A review of day shift nursing documentation was completed with the DON at this time. Nursing note documentation on [DATE] during day shift specified R701 was alert to self only, a decline from admission to the facility. The DON then stated, Well, (R701) was disorientated. When asked if the date of service of [DATE] on the note authored by Physician B in the EMR dated as [DATE] meant the Physician actually saw the (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	the R702's potassium levels, their kidneys would not have shut down.Review of R702's EMR revealed the following documentation:- [DATE] at 12:25 PM- HCP Note: Date of Service: [DATE].Reports of increased lower extremity edema with weeping and follow up of bloodwork results . Will obtain CMP [DATE].- [DATE] at 4:20 PM- HCP Note: Date of Service: [DATE]. Patient is being seen today for reports of noncompliance with fluid restriction and increased edema/weight gain. Documented weight trends reveal recorded weight of the following. 192.8 pounds [DATE]. 195 pounds [DATE]. 197.6 pounds [DATE]. plan was made with orders given to the Nursing staff to administer 10 mg (milligrams) Lasix (medication used to treat fluid retention and increase urine output) daily. and to crush pills per Patient request [ok to change potassium to liquid or sprinkles]. Nursing staff is aware to notify provider with any changes in Patient condition or vital signs.- [DATE] at 8:42 AM: INTERACT Nursing Home to Hospital Transfer Form. Reason for Transfer - SOB (Shortness of Breath) . How long has resident had illness? 24 hrs. Vital Signs . Blood Pressure - 105/68 Temperature - 98.0 . Pulse - 105 (normal- 60-100), Oxygen Saturation - 97, Respiratory Rate - 15 . Authored by Licensed Practical Nurse (LPN) K.- [DATE] at 9:42 AM- Nurses Note: Resident transported to ER for evaluation for COPD (Chronic Obstructive Pulmonary Disease) exasperation (sic) at 8:40 AM, (NP C) . notified at 8:48 AM. Authored by Licensed Practical Nurse (LPN) K.Note: COPD was not listed as a diagnosis on the Resident's face sheet/information.- [DATE] - HCP Note: Nursing staff called to report (R702) was sent to ER for complaints of dyspnea (shortness of breath).Review of VS documentation in R702's EMR revealed inconsistent documentation of VS measurements. Documentation included:- [DATE] at 10:43 AM: Blood Pressure: 111/66- [DATE] at 9:02 AM: Blood Pressure: 126/70, Pulse: 85- [DATE] at 3:28 PM: Blood Pressure: 133/84, Pulse: 68The most recent complete set of vital signs documented was on [DATE] at 4:17 AM and included: Blood Pressure: 130/68, Pulse: 68; Respirations: 18; Temperature: 96.8; Oxygen saturation: 94%Review of R702's HCP orders and MAR for [DATE] revealed the Resident was receiving the following:- Lasix 10 mg daily upon rising (Start Date: [DATE])- Potassium chloride capsule, extended release, 30 meq (milliequivalents) twice a day (Start Date: [DATE])- Spironolactone (potassium sparing medication used to treat and manage fluid retention) 50 mg daily upon rising (Start Date: [DATE])- Torsemide (medication used to reduce fluid retention by increasing urine output) 40 mg daily upon rising (Start Date: [DATE])- Metolazone (medication used to reduce swelling and fluid retention by increased urine excretion) 5 mg daily upon rising (Start Date: [DATE])Review revealed R702 had been receiving Bumex (medication used to treat excess fluid) from [DATE] until [DATE].Review of Laboratory Testing Results in R702's EMR revealed a Basic Metabolic Panel (BMP) was completed on [DATE] with the following results:- Sodium: 129 (low - normal 136-144)- Potassium: 4.7 (normal 3.4-5.0)- Blood Urea Nitrogen (BUN- blood test used to evaluate how well kidneys are functioning): 43 (elevated - normal is 10-23)- Creatine (blood test used to evaluate how well kidneys are filtering waste and functioning): 1.23 (elevated- normal is 0.60 -1.10)Review of R702's BMP results dated [DATE] revealed the Resident's potassium level was 4.2 and their sodium was 131.Review of R702's HCP orders for laboratory testing revealed an order dated [DATE] for a BMP to be completed every two weeks on Tuesday indicating a BMP should have been completed on [DATE]. There were no results in Resident #701's EMR for a BMP on [DATE].An interview was completed with LPN K on [DATE] at 9:30 AM. When asked what occurred when R702 was transferred to the hospital on [DATE], LPN K reviewed their documen