STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Wyoming	625 36th Street SW Wyoming, MI 49509

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake #2674209Based on interview and record review, the facility failed to treat one resident (Resident # 72) in a dignified manner, out of three residents reviewed for dignity and respect. Findings: Resident #72 (R72) Review of an admission Record revealed R72 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses of an infected right hip replacement and difficulty walking. During an interview on 01/05/26 at 11:26 AM, R72 reported the following details regarding an incident that occurred very early in the morning on 11/12/25, that involved R72 and Certified Nurse Aide (CNA) Y: (a) during the night/early morning of 11/12/25 CNA Y came into her room and told R72 to stop putting on her call light and that CNA Y had been into R72's room multiple times tonight and was not coming back again, (b) R72 stated that CNA Y then messed around with her bed control and call light and left the room, (c) R72 fell back asleep, woke up sometime around 5 AM and needed to go to the bathroom, (d) R72 looked for and could not find her call light, (e) R72 had a bowel movement and urinated in her undergarments because she could not find the call light to alert staff that she needed help, and (f) R72 reported that she was devastated and embarrassed by the incident and was tearful when recounting the details of the incident. It felt like she (CNA Y) didn't come back on purpose to punish me. R72 stated that she finally got help from CNA S after shift exchange. During an interview on 01/06/25 at 12:35 PM, CNA S reported that entering R72's room the morning of 11/12/25 and could smell feces and that R72 was very upset. CNA S indicated that R72's sheets were saturated with urine and feces and that the call light was wrapped up with the bed remote, on the floor, out of sight and out of reach of the resident. CNA S recalled that R72 was embarrassed about the incident. CNA Y no longer worked at the facility and could not be reached for comment.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 2664254Based on interview and record review, the facility failed to notify the provider of 1.) a change in condition and 2.) abnormal vital signs for 2 of 18 residents (Resident #90 and #81) reviewed for notification of change.Findings:Resident #90 (R90)Review of an admission Record revealed R90 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: type 1 diabetes mellitus with hyperglycemia.Review of a Facility Reported Incident (FRI) dated 9/17/25 revealed, (Hospital) patient navigator emailed facility to inform us that (R90) alleged he was being abused at our facility regarding his insulin management.Review of R90's Order Summary dated 8/6/25 revealed, Obtain Blood Sugar before meals and at bedtime before meals and at bedtime for blood glucose monitoring Less than 60 or greater than 200, notify physician.Review of R90's Blood Sugar Summary revealed:On 8/11/2025 at 9:49 PM, R90's blood sugar was 533 On 8/11/2025 at 10:50 PM, R90's blood sugar was 508 On 8/12/2025 at 1:27 AM, R90's blood sugar was 490 On 8/15/2025 at 11:23 PM, R90's blood sugar was 433 On 8/16/2025 at 7:14 AM, R90's blood sugar was 409 On 8/18/2025 at 10:09 AM, R90's blood sugar was 418 On 8/18/2025 at 10:20 AM, R90's blood sugar was 400 On 8/29/2025 at 7:44 AM, R90's blood sugar was 419 On 9/5/2025 at 11:15 PM, R90's blood sugar was 551 On 9/9/2025 at 11:29 AM, R90's blood sugar was 400 On 9/10/2025 at 4:52 PM, R90's blood sugar was 400Review of R90's Electronic Medical Record revealed no documentation that the provider was notified of the elevated blood sugar.During an interview via email on 01/08/2026 at 11:47 AM, a request for documentation that the provider had been notified of R90's elevated blood sugars was made. On 01/08/2026 at 12:15 PM, Nursing Home Administrator (NHA) stated, Unfortunately, we do not see anything documented either.During an interview on 01/08/2026 at 12:55 PM, the Director of Nursing (DON) reported that the expectation was for the licensed nurses to notify the provider of elevated blood sugars and that was typically done when a blood sugar reading was greater than 450.Resident #81 (R81)Review of an admission Record revealed R81 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease and presence of cardiac pacemaker.Review of R81's Medication Administration Record revealed a dose of Nitroglycerin Sublingual Tablet was administered on 1/5/25 at 1:49 AM.Review of R81's Nursing Progress Note dated 1/5/2026 at 01:50 AM revealed, Patient complained of chest pain on left side nitroglycerin given. BP (blood pressure) 158/90 P(pulse) 73 R (respirations) 18 T (temperature) 97.3 Sats (Oxygen Saturation) 93% at room air. Nurse notified patient's wife of patient's condition and she stated to continue to monitor and she will be in this morning. Per Fundamentals of Nursing ([NAME] and [NAME]) 11th edition a myocardial infarction (heart attack) in men is usually described as crushing, squeezing, or stabbing. The pain is often in the left chest and sternal area.Review of R81's Nursing Progress Note dated 1/5/2026 at 2:31 AM revealed, Received call back from patient's wife CNA (Certified Nursing Assistant) reports patient resting quietly in bed. Patient's wife stated that if he becomes worse to send him to (name omitted) Hospital for evaluation.Review of R81's provider Progress Note dated 1/6/26 at 8:59 AM revealed he was assessed by the provider for elevated sugars.Review of R81's provider Progress Note dated 1/6/26 at 10:33 AM revealed he was assessed by the provider for emergency room and UTI (urinary tract infection) follow-up.Review of R81's Electronic Medical Record revealed no documentation that the provider had been notified of the episode of chest pain despite R81's complex history of heart disease and other comorbidities.Review of the Provider Communication Log revealed no documentation that the episode of chest pain was documented for provider follow-up.On 01/07/2026 at 2:07 PM, the Director of Nursing (DON) confirmed that there was no documentation that the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider had been notified of the episode of chest pain.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Be aware of the following common negligent acts that have resulted in lawsuits against hospitals and nurses (Frank and [NAME], 2019; Grant and [NAME], 2018): Failure to follow the standard of care Failure to communicate (e.g., failure to notify the health care provider of abnormal assessment data or significant changes in a patient's status) Failure to document care and evaluation of care provided to the patient Failure to assess and/or monitor, including making a nursing diagnosis. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: 2641157Based on interview and record review, the facility failed to 1.) prevent misappropriation of resident medication and 2.) monitor and investigate the potential/ongoing misappropriation of resident narcotic medication for 2 residents (Resident #38 and #41) out of 7 residents reviewed for the misappropriation of medications, resulting in the diversion of medications and the potential for ongoing diversion of medications. Findings:Resident #38 (R38)Review of an admission Record revealed R38 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: type 2 diabetes.Review of R38's Facility Reported Incident (FRI) dated 10/29/25 revealed, .Verified The allegation was supported by evidence collected during the investigation.On 10/28/25 (Registered Nurse [RN] GG) accepted the Ozempic from the pharmacy at 11:30pm and had it in her possession. She received the medication from pharmacy then attempted to get (Licensed Practical Nurse [LPN] KK) to co-sign with her. This was concerning to (LPN KK) as it was already in (RN GG's) possession. (LPN KK) reported this to the DON (Director of Nursing) at 06:40am on 10/29/25. When first shift arrived at 0700am the medication was unable to be located. (RN GG's) statement was that she couldn't be responsible for the Ozempic because it was not her assigned resident. Packing slips for all meds delivered were recovered-except for the Ozempic.(RN GG) was stated by multiple co-workers that she was often communicating/inquiring about medications for weight loss.RCA highlighted the need for controlled access to GLP1s (type of medication) due to cost which was immediately implemented and all licensed nurses were re-educated on the process.(RN GG) was called on 10/31/25 and 1/03/25. Messages were left and there was no response to the facility. This was an isolated incident in which the facility responded promptly and replaced the Ozempic at facility cost. There were no missed doses or delays. There was no harm to the resident (R38).Resident #41 (R41)Review of an admission Record revealed R41 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain in left and right knees.Review of a Minimum Data Set (MDS) assessment for R41, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R41 was cognitively intact. Review of R41's Order Summary dated 11/15/24 revealed, HYDROcodone-Acetaminophen (Norco) Tablet 5-325 MG Give 1 tablet by mouth every 12 hours as needed for breakthrough pain management.Review of R41's Controlled Drug Receipt/Record/Disposition Forms revealed that from 10/25/25-1/4/26 only 1 nurse (LPN HH) dispensed the Norco to R41. No other licensed nurses dispensed any tablets of Norco to R41.An entry between 12/22/25 and 1/3/26 indicated a correct count was completed indicating a tablet of Norco was missing and could not be accounted for.During an interview on 01/07/2026 at 8:31 AM, R41 reported she took pain medication at night which was effective in controlling her leg pain. R41 confirmed the medication was Tylenol and was scheduled (not administered as needed). R41 reported she did have an order for as needed pain medication (Norco) but never asks for it as her pain was controlled without it.During an interview on 01/07/2026 at 2:20 PM, the DON reviewed R41's Controlled Drug Receipt/Record/Disposition Forms and confirmed that only 1 nurse dispensing a narcotic appeared suspicious for narcotic diversion.During an interview on 1/7/26 at 3:47 PM, the NHA confirmed what R41 had reported of the scheduled evening Tylenol being effective for her pain control and not requiring the as needed Norco. The NHA reported LPN HH would be suspended pending a misappropriation/diversion investigation.Review of the facility policy, Controlled Medication Guidelines last revised 3/20/24 revealed, .Suspected tampered packages (i.e. vials without tamper evident caps or taped punch cards) and unresolved discrepancies in the count must be reported immediately as follows: Notify the DON, charge nurse/ or designee and the pharmacy. Staff may not leave the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area until discrepancies are resolved or reported as unresolved discrepancies. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted. The DON, charge nurse, or designee must also report any loss of controlled medications where theft is suspected to the appropriate authorities such as local law enforcement. Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2629685Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:On 01/05/2026 at 9:06 AM, observed hand towels were not readily available at the handsink in the dishwashing room. This is the only designated handsink for the kitchen. According to the 2022 FDA Food Code section 6-301.12 Hand Drying Provision.Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with:(A) Individual, disposable towels; Pf (B) A continuous towel system that supplies the user with a clean towel; Pf or (C) A heated-air hand drying device; Pf or (D) A hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures. PfOn 01/05/2026 at 9:10AM, observed filters were not in the face of the hood ventilation system, over the cookline. On 01/05/2026 at 9:20AM, during interview, Dietitian DD stated the filters have been out of the hood system for cleaning since Friday 1/2/2026. Dietitian DD stated the hood was not operational and Dietitian DD was observed turning off the hood. According to the 2022 FDA Food Code Section 4-301.14 Ventilation Hood Systems, Adequacy. Ventilation hood systems and devices shall be sufficient in number and capacity to prevent grease or condensation from collecting on walls and ceilings.On 01/05/2026 at 9:27AM, observed resident's food, an orange/brown colored sauce in foam takeout container, with a date of 12/31/2026. Resident's foods are stored in the pantry refrigerator. At that time interview with Dietitian DD stated that the facility policy was to hold the time/temperature controlled for safety food for 3 days and then discarded. On 01/05/2026 at 10:00AM, Vital therapeutic nutrition supplement product observed with an expiration date of 1 [DATE], product was sitting on shelving in back room with other therapeutic nutrition supplemental products. According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .On 01/05/2026 at 9:34AM, observed in dining room, the handsink was leaking. The water that was leaking was cold water. Dietitian DD stated the faucet was repaired the week prior for same issue. According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.On 01/05/2026 at 10:00AM, it was observed that various kitchen personnel were leaving other tasks and then handling clean dishes without washing their hands. Personnel were also observed taking off their gloves and not washing hands before putting on new gloves.On 01/05/2026 at 11:00AM, observed several kitchen personnel leave the kitchen area, come back into kitchen and begin working with equipment to prepare for lunch without washing their hands. According to the 2022 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and:(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; (E) After handling soiled (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.On 01/05/2026 at 10:05AM, observation of dish machine operation, disclosed the sanitizing rinse was not reaching 180 degrees F on the gauge readout and not reaching a plate surface temperature of 160 degrees F. Plate surface temperature was tested using a DishTemp plate simulating tester. The reading on the tester was a maximum temperature of 146 degrees F. Interview with Dietitian DD at this time, regarding temperatures and procedures for dish machine operation, confirmed the minimum temperatures of 180 degrees F hot water at gauge readout and 160 Degrees F for plate surface temperature. According to the 2022 FDA Food Code Annex 3. Public Health Reasons/Administrative Guidelines section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multiuse utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least 71 C (160 F) as measured by an irreversible registering temperature measuring device to affect sanitization. When the sanitizing rinse temperature exceeds 90 C (194 F) at the manifold, the water becomes volatile and begins to vaporize reducing its ability to convey sufficient heat to utensil surfaces. The lower temperature limits of 74 C (165 F) for a stationary rack, single temperature machine, and 82 C (180 F) for other machines are based on the sanitizing rinse contact time required to achieve the 71 C (160 F) utensil surface temperature. According to the 2022 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90C (194F), or less than: (1) For a stationary rack, single temperature machine, 74C (165F); or (2) For all other machines, 82C (180F).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake 2643393. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 of 18 sampled residents (R74). Findings include: A review of R74's admission Record, dated 1/7/26, revealed R74 was an [AGE] year-old that was admitted to the facility on [DATE]. In addition, R74's admission Record revealed multiple diagnoses that included dementia with agitation and psychotic disturbance, anxiety, and bipolar disorder. A review of R74's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 11/22/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R74 was cognitively intact. A review of the facility's investigation report, dated 9/30/25, revealed on 9/23/25 at 11:00 AM, the Nursing Home Administrator (NHA) was notified by a nurse aide that R74 alleged he was yelled at by Certified Nursing Assistant (CNA) G a few days ago and it was upsetting to him. The NHA went to speak to R74, but he could not recall the name of the aide that yelled at him but did state that he was upset because he felt he was yelled at when he was just trying to tell the aide that his roommate's urinal should not be in the bathroom. During an interview on 1/5/26 at 1:00 PM R74 stated he has had some issues with staff. He stated he has only had an altercation with one aide and it was just a verbal altercation. R74 stated the staff member touched his things and he yelled at her. He stated he told her to get the h*** out of my room. R74 did not remember the aide's name that he had a verbal altercation with and he did not remember any other incidents besides that one. A review of R74's typed interview statement, dated 9/26/25, revealed R74 stated he told the aide that the urinals do not belong in his bathroom. He stated the aide spoke to him in a way he did not like. R74 stated he did not remember the aide's name. He also stated he was not scared and felt safe in the facility. A review of CNA H's typed and signed statement, dated 9/23/25, revealed R74 called her over and told her about the interaction he had with an aide a few days before. She stated he told her that he was arguing with CNA G about the urinal being left in the bathroom, that he had removed it from the bathroom, and that he threw it on the floor. He told her that CNA G was screaming at him and that RN F intervened. CNA H stated that R74 seemed fearful when he stated that he would protect himself from her if he had to. CNA H stated she immediately reported this incident to the facility abuse coordinator. A review of R74's electronic medical record, dated 9/8/25 to 10/6/25, failed to reveal any mention of an incident between R74 and staff on, or around, 9/23/25 and/or any follow-up visits after a possible incident (e.g., social service visits evaluating R74's psychosocial well-being). In fact, R74's electronic medical record failed to reveal any incidents during this time where R74 was yelling/verbally aggressive towards staff and/or staff were yelling/verbally aggressive towards him. During an interview on 01/07/2026 at 2:15 PM, the Director of Nursing (DON) stated she would expect that if a resident complained that a staff member yelled at them then the nurse would write a progress note. She then said she was not sure if the nurse would document if a resident made an accusation that a staff member yelled at them or swore at them in a progress note or where it would be documented, if at all. She further stated staff would definitely document if a resident yelled at staff or if they swore at staff. The DON finally stated she would have to ask the NHA if staff would document an accusation in the resident's medical record that staff yell or swore at them and where it would be documented. During a second interview on 01/07/2026 at 2:25 PM, the DON stated she spoke with the NHA. She stated the NHA told her that if a resident accused staff of yelling at them or swearing at them, then it would be documented in [name of the system the facility uses to report incidents to the State (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Survey Agency] and in a risk management form. She stated the NHA said all the documents go there. The DON further stated that the accusation would not be documented in the resident's medical record. She also stated that she did not think that staff would document that they notified the NHA/facility abuse coordinator in the resident's medical record. She stated that it would all be in the investigative file (an internal file that was not a part of a resident's medical record) During an interview on 01/07/2026 at 2:50 PM, the NHA stated when she gets an allegation (e.g., a staff member yells at a resident) she puts the information in [name of the system the facility uses to report incidents to the State Survey Agency]. She stated she also starts a risk management form for the incident and the information is put in there. She further stated the risk management form is a facility internal document and is not a part of the resident's medical record. The NHA also stated they do not document the information for an allegation that staff yelled or swore at a resident (an allegation of abuse) in the resident's medical record. She stated even though they do not document the resident's initial accusation in their medical record, the social worker will do follow-up visits related to the allegation to ensure the resident feels safe at the facility and does not have any negative outcomes from the allegation. The NHA stated the social worker's follow-up visits should be documented in the resident's medical record. She also stated that R74 yells at staff frequently and that should be documented in R74's medical record. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care- Assessments; Clinical problems; Communications with other health care professionals regarding the patient; Communication with and education of the patient, family, and the patient's designated support person and other third parties. Patient responses and outcomes, including changes in the patient's status . Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 7/27/25).