STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235477	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomeroy Living Rochester Skilled Rehabilitation	3500 West South Blvd Rochester Hills, MI 48309

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 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to the complaint: 2594578. Based on interviews and record reviews the facility failed to timely identify signs/symptoms of a urinary tract infection (uti), failed to consistently inform the Physician/NP (nurse practitioner) of identified signs/symptom, and failed to timely treat a uti for one (R202) of three residents reviewed for a change of condition, resulting in the resident to be hospitalized in the intensive care unit for urosepsis (urinary tract infection spreads to the bloodstream) and ultimately admitted into hospice care. Findings include:A review of a hospital Emergency Medicine consult dated 8/19/25 at 11:55 AM, documented in part . present to the Emergency. for altered mental status and hypotension. they <sic> she is acting worse than baseline. Patient is unable to provide any history at this point in time. They identified that the patient's urine is foul smelling. She does have a Foley catheter in place. Tachycardia present. Respiratory distress present. Laboratory evaluation identifies a significant urinary tract infection and evaluation of the CAT scan identifies that the Foley catheter that was recently placed may not have been completely inserted. When it was removed the area was covered with stool. The patient is dehydrated and initially was hypotensive though that has improved during her emergency department stay. Sepsis. Final Impression: 1)AMS (altered mental status) 2)UTI 3)Sepsis 4) palliative care.A review of the medical record revealed R202 was transferred from another nursing facility and admitted to the facility on [DATE], with a diagnosis of dementia. The resident was documented to have severely impaired cognition and required staff assistance for all activities of daily living.Review of the transferring nursing home documentation provided to the facility staff upon R202's admission revealed no documented behaviors or urinary concerns. A review of a Physician History and Physical dated 8/1/25, documented in part . transferred from (previous nursing home name) for placement, she is seen and examined, laying in bed comfortably, not in distress, no new complaints, no new events over night, and no new issues per nursing staff. Foley catheter. No change in cognition. in no acute distress.A review of the progress notes revealed the following: A nursing note dated 8/2/25 at 1:25 AM, documented in part Observed resident continuingly removing brief and clothes and pulling call light cord out of the wall. Resident is in a very confused mental state at this time. Observed crying and pulling at shirt to remove immediately. Observed thick cloudy urine in foley tubing. Foul odor to urine.There was no documentation of the Physician to have been notified of the abnormal urine findings. A nursing note dated 8/4/25 at 11:01 AM, documented in part residents urine bag was changed due to the old one clogged with sediment.A nursing note dated 8/10/25 at 6:24 PM, documented in part . Resident foley is draining appears very dark in color, unsure if due to dehydration or blood due to resident continuously pulling at indwelling foley. Will leave message in dr (doctor) book regarding issue.A nursing note dated 8/12/25 at 2:54 PM, documented in part . Writer noted cloudy and discoloration to urine, increased confusion and resident presented with back pain. NP (nurse practitioner) in house and ordered for urine dip and if positive to send out. Writer dipped urine with 125++ noted of leucocytes <sic>. Urine placed in total lab book for p/u (pick up). Writer changed Foley catheter bag and irrigated Foley, Labs also placed for CBC (complete blood count) and CMP (comprehensive metabolic profile) for 8/13/25.A nursing note dated 8/13/25 at 11:27 AM, documented in part . Assistance provided with breakfast. stating she did not want any more as she was about to throw up. refuses to consume more than 1 or 2 sips of water, UA (urinalysis) still pending, no results yet.A nursing note dated 8/14/25 at 6:15 PM, documented in part . Foley draining but odd coloring, full of sediment. Still awaiting urinalysis results.A nursing note dated 8/16/25 at 6:38 PM, documented in part . resident was baning <sic> her hand repeatly <sic> on the table and screaming. Family was called to help console the resident.A nursing note dated 8/16/25 at 6:42 PM, documented in part . resident was up the whole night screaming, banging her hand on the table and grabbing her foly <sic> and wrapping it around her head.A nursing note dated 8/17/25 at 12:19 AM, documented in part . observed by nurse laying in bed playing in her stool. Resident with stool all over her hands.A nursing note dated 8/18/25 at 2:07 AM, documented in part . Resident complains of back pain Tylenol provided and norco (controlled pain medication) reordered.A nursing note dated 8/18/25 at 4:41 AM, documented in part . Resident has a pending UA and CS (culture and sensitivity). Lab book states CMP (comprehensive metabolic panel) and CBC (complete blood count) blood specimen pending.A review of a urinalysis, urine culture and sensitivity report collected on 8/12/25 and resulted on 8/18/25, revealed an abnormal UA with an identified organism of > (more than)100,000 of E.Coli present in R202's urine. The report noted the antibiotics the organism was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to the complaint: 2594578. Based on interviews and record reviews the facility failed to order laboratory tests as directed by the Physician/Nurse Practitioner, ensure timely/efficient laboratory services, ensure promptly notify the Physician of abnormal results and failed to develop a policy and/or procedure for ordering laboratory test, obtaining & reporting abnormal values to the Physician for one (R202) of three residents reviewed for a change in condition. Findings include: A review of the medical record revealed R202 was admitted to the facility on [DATE], with a diagnosis of dementia. The resident was documented to have severely impaired cognition and required staff assistance for all activities of daily living.A review of a nursing note dated 8/12/25 at 2:54 PM, documented in part . Writer noted cloudy and discoloration to urine, increased confusion and resident presented with back pain. NP (nurse practitioner) in house and ordered for urine dip and if positive to send out. Writer dipped urine with 125++ noted of leucocytes <sic>. Urine placed in total lab book for p/u (pick up). Writer changed Foley catheter bag and irrigated Foley. Labs also placed for CBC (complete blood count) and CMP (comprehensive metabolic panel) for 8/13/25. care updated. A review of a nursing note dated 8/18/25 at 4:41 AM, documented in part . Resident has a pending UA (urinalysis) and CS (culture and sensitivity) <sic>. Lab book states CMP and CBC blood specimen pending.A review of the medical record revealed the CBC and CMP order was never implemented as directed. Further review of the medical record revealed no results of a CBC or CMP. A review of a urinalysis, urine culture and sensitivity report collected on 8/12/25 and resulted on 8/18/25, revealed an abnormal UA with an identified organism of > (more than)100,000 of E.Coli present in R202's urine. The report noted the antibiotics the organism was resistant and sensitive to. Review of the medical record revealed no documentation of the identified abnormal UA and C&S, no notification to the Physician/NP and no treatment implemented for the infection. Further review of the urinalysis, urine culture and sensitivity report noted on the bottom sent on this AM (clinician's initials) 8/19/25. This indicated the staff failed to report the results to the Physician/NP on 8/18/25 and was delayed a day and sent to the Physician/NP on 8/19/25. The collected date of the urinalysis was noted on the report as 8/12/25 and the resulted date was noted as 8/18/25, a six-day delay from the facility's contracted lab to have reported the abnormal urinalysis to the facility and the delay in the reporting of the culture and sensitivity results. Review of a nursing note dated 8/19/25 at 11:16 AM, documented in part . Resident was sent to (hospital name) for evaluation vis <sic> EMS (emergency medical services), resident urine appeared dark emesis in color, Resident was experience <sic> mental status change without following command.On 8/26/25 at 9:27 AM, the Administrator was asked to provide the facility policy on the ordering and report of lab results. At 10:08 AM, the Administrator replied the facility did not have a policy regarding the ordering and reporting of lab results. On 8/27/25 at approximately 8:27 AM, the Director of Nursing (DON) was interviewed and asked about the facility's protocol regarding implementing and ordering the labs as directed by the Physician/NP and the DON replied the facility staff put in the orders into the laboratory website and the lab worker would come to the facility in about two days, stat (immediate) right away if needed. The DON was asked the facility's protocol in how the staff identify and report abnormal lab findings to the Physician. The DON stated the lab results are emailed to them (DON) and faxed to the facility. The DON explained Monday through Fridays the unit ward clerk would obtain the faxed laboratory reports and provided them to the staff. The DON stated on the weekends the Nursing supervisor would obtain the reports and provide it to the staff. The DON was asked about the CBC and CMP that was supposed to be ordered for R202. The DON stated they saw that it was documented and noted to be pending, however the facility did not have the results. The DON stated they had identified issues/concerns with the facility's contracted lab services and was working toward a solution. The DON was then asked about R202's abnormal UA and C&S results to have been reported on 8/18/25, however not reported to the Physician until 8/19/25. The DON stated they recognized the long processing times with the third-party laboratory to have been problematic and stated the nurse should have followed up on 8/18/25 when the abnormal UA & C&S was completed to report it to the Physician. The DON stated they had started education with the nursing staff regarding the concern. No further explanation or documentation was provided.