STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235733	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Troy	2685 West Maple Road Troy, MI 48084

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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	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to Intake MI00152492 Based on observation, interview and record review the facility failed to accurately assess, monitor, and document, catheter care for three residents (902, 904, 905) of three reviewed for catheter use. Additionally, the facility failed to document Urology Consultations, and evaluate the long term administration for Pyridium (analgesic medication used to relieve urinary tract discomfort, including pain, burning, and urgency) resulting in the delay of diagnosing and treatment of a Urinary Tract Infection (UTI), Sepsis (an infection causing injury to its own organs) and hospitalization and subsequently death. Findings include: R902 A complaint was filed with the State Agency (SA) that alleged R902 complained of pain in the bladder area on [DATE] and the facility did not attend to the concern until [DATE]. The complainant further alleged they requested R902 be sent to the hospital and the facility failed to do so until several hours after R902 voiced their concerns of pain and no urine output. The complainant alleged when R902 arrived at the hospital it was determined that the resident was in septic shock due to a UTI and expired approximately 12 days later. Review of R902's Certificate of Death (date signed [DATE]) documented in part, . Cause Of Death .Sepsis . Immediate Cause . Urinary Tract Infection . On [DATE] at 10 :11 AM, a telephone Interview with the complainant confirmed R902's medical history, allegations, and provided a timeline of the alleged events between the facility and R902 as follows: [DATE] 9:48 AM, R902 contacted their spouse and stated they were not feeling well all night, felt shaky, and had pain in their abdominal area. [DATE] 9:52 AM, R902 expressed continuous complaints regarding severe shaking and trembling from R902 to spouse over the phone. Nursing was called by R902's spouse with their concern and there was no response. (continued on next page)

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

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F 0690 Level of Harm - Actual harm Residents Affected - Few	[DATE] 11:33 AM, spouse called Nurses desk, informed they (Spouse) placed a call two hours prior and still have not received a call regarding symptoms and requested that someone call back ASAP (as soon as possible). [DATE] 12:36 PM, family arrived at the facility and R902 was observed shaking while they tried to bring a cup with the straw to their mouth. Said they were hurting on the lower right side (abdomen) but sometimes felt like it was radiating to the left, and that it hurt in the middle and felt like it was their bladder area. R902 was shaky, very panicked, not themselves. Family observed no urine in their catheter bag, abdomen was firm, distended, and painful, and R902 said it hurts in my bladder. [DATE] 12:52 PM, Licensed Practical Nurse (LPN) A and Unit Manager LPN (UMLPN) E, were asked about the empty urine bag and asked when it was last emptied to which UMLPN E replied, things like that aren't kept track of. Family further informed Nursing that R902 experienced pain and distention in their right lower quadrant (abdomen) and suprapubic (bladder) areas and felt that it was bladder pain and was concerned there was no urine output. Nursing was unable to confirm when the last time there was urine. The family reminded Nursing that R902 had a history of UTI's, and requested a urine sample be tested , to which UMLPN E told the family the Nurse Practitioner (NP) ordered a stomach x-ray instead. [DATE] at 1:57 PM, Family observed no urine in the catheter bag which was not normal for R902 seeing they were diabetic. The family alleged R902 remained with a firm, distended, painful abdomen. [DATE] at 3:13 PM, Spouse called Nursing staff and requested an update on R902's pain, distention and urine output, at which time they informed there was no urine in the catheter bag. The spouse insisted because their bag had been dry for hours R902 needed immediate hospital treatment. [DATE] at 5:03 PM, R902 contacted their spouse indicating they were still in a lot of pain in the bladder area, and it is getting worse and had no update from Nursing about the stomach Xray. [DATE] at 5:28 PM, LPN A contacted the spouse informing they tried to replace the catheter with no success. [DATE] at 6:25 PM, record review of the Nursing Progress Note authored by LPN A documented: .Resident was observed not having much urine output . beige discharge was observed during catheter replacement . Record review of R902's hospital records date of service Emergency Medicine [DATE] at 7:26 PM, documented, in part, the following: .has a Foley catheter .daughter noticed an empty urine bag, and the staff could not confirm when it was last emptied . Consult from Urology .inspected Foley catheter and was determined not to be in the appropriate position . presented on [DATE] for severe sepsis secondary to UTI with obstructive uropathy . Further hospital record review of the Computed Tomography (CT) scan of abdomen and pelvis, .Findings suggestive of underlying cystitis (bladder infection) involving both kidneys . bilateral hydronephrosis (swelling of the kidneys due to the buildup of urine)/hydroureter (swelling of the ureter due to urine back up) .Later in the evening, the patient's sepsis worsened .did not want aggressive measures .transferred to Hospice [DATE] .remained under inpatient hospice care .until death [DATE] . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	A review of R902's clinical record revealed the resident was transferred from the hospital to the facility on [DATE] with a primary diagnosis that included: Urinary Tract Infection (UTI) and required continued medical care and physical rehabilitation. Medical clinical history included a history of diabetes, neurogenic bladder (lack of bladder control) as a result from surgery in 2024 for spinal stenosis (condition that narrows the spine and places pressure on spinal cord) and recurrent UTI's. R902 was admitted to the facility with a UTI and Foley catheter (placed in hospital prior to transfer) and was to maintain the catheter until evaluated by Urology. Brief Interview of Mentals Status (BIMS) was ,d+[DATE] indicating R902 was cognitively intact. Further review of R902's clinical record revealed there was no documentation of R902 having an order for a Foley catheter including the medical necessity and or medical diagnosis. Interventions listed within the careplan included changing the catheter and tubing per policy and as needed, yet there was no documentation in the electronic medical record (EMR) this was completed. Careplan documented .at risk for urinary tract infection and catheter related trauma has foley catheter .observe, record, report discomfort on urination and frequency . On [DATE] at 12:27 PM, a telephone interview was conducted with LPN A and confirmed they were aware R902 was complaining of abdominal pain and were being assessed for GI (gastrointestinal) and not urinary tract because R902 had complained of diarrhea. LPN A also mentioned R902 had a low blood pressure. LPN A said they were informed by family at bedside there should have been urine in the bag. LPN A acknowledged it was was unclear when it was emptied, and did not recall if there was documentation of catheter care. When questioned to clarify the Nursing Progress Note dated [DATE] at 6:25 PM documenting . beige discharge was observed during catheter replacement . LPN A confirmed they pulled the catheter and tried to insert another without success. When asked to clarify what meant without success, LPN A said they had resistance advancing the catheter, could not confirm placement, left it (catheter) in the urethra, and commented there was a liquid substance (discharge) observed leaking out the penis around the partially inserted catheter. On [DATE] at 10:33 AM, An interview was conducted with the Director of Nursing (DON), Nurse Practitioner (NP) D and UMLPN E regarding the events pertaining to R902's on [DATE]. UMLPN E confirmed they received a call from R902's spouse indicating they were complaining of chills and tremors. UM LPN E simplified they did not perform a physical assessment and only reported the complaints they received from the spouse over the phone which was the only information they conveyed to NP D. UMLPN E acknowledged they were present and assisted LPN A with replacing the catheter. UMLPN E remarked it was difficult to advance the catheter because there was a crusty discharge at the top of the penis. When inquired if there was documentation of the discharge prior to their observation, UMLPN said there was no documentation of any catheter care and therefore unable to know for certain. Record review from NP D Progress Note dated [DATE] 00:00 (per facility this is a default time, actual time of the NP being there is not recorded) documented: .Nursing staff reports that patient has hypotension and complaints of chills. Patients is still in bed and appears anxious. Patient complains of having chills and tremors .just does not feel good all over .Current blood pressure ,d+[DATE] .Positive for fatigue Notes: I have chills Blood Sugar 334 .Positive: Tachycardia .Abdomen firm and distended . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Record review revealed NP D did not document a genitourinary (relating to the genital and urinary organs) assessment. On [DATE] at 10:33 AM, during an interview with NP D they acknowledged they were informed by UMLPN E the spouse had called and wanted R902 to be seen for complaints of chills and not feeling right. NP D was not familiar with R902 but because they were in the building, they came to assess. NP D confirmed based on the complaint of abdominal pain and diarrhea, NP D focused on a gastrointestinal rule out, and did not identify any assessment with R902's urinary catheter. When questioned why Midodrine (medication to treat low blood pressure) was given when R902 complained of chills, demonstrated anxiety and reported new onset hypotension, they replied that it was normal practice if the systolic blood pressure (top number) was under 100. When asked if sepsis was considered, they replied they were focused on ruling out an ileus (lack of movement in the intestines) and dehydration. NP D could not recall if they followed up on the ordered abdominal x-ray results. Record review revealed the Abdominal X-ray Radiology Result Report dated [DATE] at 13:39 (1:59 PM) concluded: Nonobstructive gas pattern. There was no documentation from the Providers that the results were reviewed as a rule out for the ileus and R902 was still having abdominal pain, distention, chills, and no/low urine output. On [DATE] at 3:40 PM, a telephone interview was conducted with NP C and inquired why they ordered two urinalyses with culture in such close date proximity. NP C could not recall why the first test ([DATE]) was ordered, but recognized on [DATE] when they went to see R902. NP C recalled the urine in the catheter bag looked cloudy and R902 was complaining of signs and symptoms of a UTI . NP C identified when they returned on [DATE], the test was not performed on [DATE] (record review documented the test was signed off by Assistant Director of Nursing) and had to be reordered. Record review revealed NP C documented on [DATE] .Urinalysis was reviewed with the patient; negative . Patient still complaining of burning at the tip of the penis .Pyridium ordered for relief; will follow up with patient for symptom relief .Medication ordered [DATE]-Phenazopyridine HCl Tablet 100 MG (milligrams) Give 1 tablet by mouth one time a day for Burning when peeing . Per the website Drugs.com-Phenazopyridine (Pyridium) is a medication used to relieve urinary tract discomfort, including pain, burning, and urgency, and works as local analgesic (pain relief) in the urinary tract (bladder and urethra). Warnings .this medication will treat the symptoms of a urinary tract infection, but this medication does not treat the actual infection .the color of the urine will turn orange or red in color .Pyridium is not recommended for more than two days and generally used for acute use to relieve urinary tract pain . using it longer than recommended may mask underlying issues that require treatment . The Medication Administration Record (MAR) revealed Phenazopyridine HCL Tablet 100 MG (milligram) Give 1 tablet by mouth one time a day for Burning when peeing Start date [DATE] and documented this medication was administered daily from [DATE] until day of day of hospital discharge [DATE]. During the interview, NP C was asked if they were aware R902 remained on Pyridium for multiple weeks, and they could not confirm why it was ordered for so long and acknowledged it was not a long-term medication. NP C was not aware Nursing was still administering based on parameters .Burning with peeing . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:48 PM, an interview with Medical Director (MD) B was conducted and when asked how long a patient should be on Pyridium, they responded only a few days. During the interview, MD B acknowledged when residents are admitted to the facility with urinary catheters, documentation is recorded in the initial History and Physical (H&P) and the Provider places an order to maintain the catheter along with the medical diagnosis and necessity for it. MD B said to confirm with the DON, but it was their knowledge that the order for the catheter should then trigger Nursing catheter care (in the EMR). Review of R902's EMR under Physician Orders revealed no documentation of an order to maintain the urinary catheter nor a diagnosis of why it was to be maintained. The DON was asked how documentation is triggered within the EMR and confirmed orders are placed by the Physician and also captured by the MDS (Minimal Data Set) Nurse. The DON reviewed R902's EMR and confirmed there were no Nursing or CNA documentation to support any catheter care was performed, including documentation to support how much urine was emptied, when catheter care was performed, and if the catheter was replaced. The DON remarked, There had to be some care done because R902 was there for two months, and the bag had obviously been emptied. When asked if the catheter was in fact being emptied over two months, how come Nursing never thought of documenting or questioning the care required for R902. The DON had no comment. On [DATE] at 3:00 PM, during record review, Urology consultations were not identified, and the DON was questioned where the Urology consults were located for R902. The DON reviewed the EMR and was unable to locate and remarked they recently terminated their Medical Records employee (week prior to this interview) and the documentation might be in a box amongst other paperwork. On [DATE] at 4:30 PM, the DON returned with newly faxed paperwork from the Urology office ([DATE] 4:17 PM) and revealed the following: R902 was seen by Urology (off site) while a resident at the facility on [DATE], [DATE], and [DATE]. The Facility had no documented collaboration with Urology from these visits and could not verify if further recommendations were made on behalf of R902 and their urinary catheter. 34275 R904 On [DATE] at approximately 12:08 PM, R904 was observed sitting in a wheelchair. Their hair appeared greasy, and they had long nails. The resident was alert and able to answer most questions asked. R904 reported they had been at the facility since the end of [DATE] for rehabilitation. The resident was asked if they had a foley catheter and they noted that they did and stated it was hooked to their leg, underneath their pants. When asked if staff were caring for them, including their catheter, the resident noted that they think so. A review of R904's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Intussusception (a form of bowel obstruction where one segment of the intestine folds inside another), type II diabetes, and acute respiratory failure. A review of the resident's most recent MDS noted the resident had a BIMS score of ,d+[DATE] (cognitively intact). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Continued review of R904's clinical record, documented: [DATE]: Nurses Notes: Foley Query form placed on MD (medical doctor) board for a proper diagnosis or to start trial void . [DATE]: ORDER: Provide Foley Care Daily Q (every)-Shift . [DATE]: ORDER: DC (discontinue) Foley Catheter. Void trials. If no urine output in 6 hours: Bladder scan, if bladder scan is >350 cc (cubic centimeters), ok to straight cath . *It should be noted that there were no documents in R904's clinical record that indicated a straight cath (catheter) was attempted. [DATE]: Progress Note: .Patient is in bed alert .Right arm is swollen .Physical Exam .Positive: Urinary Catheter .Foley .Notes: thick pale-yellow urine .Assessment and Plans .Foley catheter patent with thick pale-yellow urine .Monitor of s/s of obstruction or infection. Monitor output . A review of R904's Medication/Treatment Administration Record (MAR/TAR) from [DATE] - [DATE] showed no indication of the resident's urine output. A review of R904's Kardex/TASK electronic record showed no indication that R904's urine output was recorded. [DATE]: Progress Note: .Patient states he has a fear of not going home .Physical Exam .Positive: Urinary catheter .thick pale urine with heavy sediment .Foley cath patent. Hazy yellow with sediment .UACS (Urinalysis -Culture Sensitivity) ordered. *It should be noted that no order for UACS was noted in the resident's clinical record on [DATE]. [DATE]: Nurses Notes: .Resident alert and verbally responsive .Foley cath with foul smelling urine. New order for U/A . *It should be noted that no order was noted in the resident's clinical record on [DATE]. [DATE]: Order: UACS .One time only for UTI/Heavy urinary sediment for 2 days . (Pending confirmation). Reviewed on [DATE] at approximately 9:00 AM. A review of R904's lab results was conducted on [DATE] at approximately 10:00 AM. The last lab results noted in the residents' record was dated [DATE]. On [DATE] at approximately 10:15 AM, R904 was observed in his room sitting on their wheelchair. There was a foul odor noted in the resident's room. The resident was alert and able to answer some questions, however when confused they contacted their wife via phone. When asked if the facility had obtained lab work at any time this morning, R904 and their wife were not able to provide an answer. R905 On [DATE] at approximately 12:20 PM, R905 was observed lying in bed. The resident was alert but unable to answer questions asked. The resident had a foley catheter inserted. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	A review of R905's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnosis that included: Urinary Tract Infection (UTI) and Type II Diabetes. A review of the resident's MDS indicated R905 had a BIMS score of ,d+[DATE] (cognitively impaired). Continued review of R905's clinical record revealed, in part, the following: [DATE]: History and Physical: .Patient .was recently hospitalized for UTI .has been discharged to (name redacted) Facility .He is non-verbal, per staff does not speak any English . [DATE]: Progress Note: .R905 .patient complains of urinary retention. Patient's daughter requesting to see provider. Daughter is present at bedside translating for patient .During discussion patient states he does not pee much and that he dribbles a lot. This is incongruent with what nursing staff has been reporting. Daughter is concerned about dad having another major urinary tract infection because he has had retention issues in the past .Discussed with daughter that we would do bladder scans for postvoid residual (PVR) and that if he has 2 or more residuals that were greater than 300 <sic> we can discuss foley insertion . (Authored by NP D). [DATE]: Progress Note: .R905 being seen today for postvoid residual greater than 350. Nursing staff reports patient has not urinated sufficient amount that patient has just been having dribbles .Foley catheter 18 French with 10 cc balloon inserted under sterile technique .Discussed with nurse to make sure that patient output is monitored encourage fluids and cath care daily and as needed .PVR >350 Suprapubic pain and dribbles .Continue to monitor urine output. Monitor of s/s (signs and symptoms) of UTI . (Authored by NP D). [DATE]: Progress Note: .Patient has leg bag .Monitor I/O (input/output). Catheter care QD (daily) and PRN (as needed) . [DATE]: Physician Note: .R905 was seen and evaluated today to assess progress with therapy. He was sleeping in bed. The patient remains very fatigued . [DATE]: Nurses Notes (7:30 AM): Resident was sent to hospital for a change in mental status. Resident was observed vomiting . [DATE]: Nurses Notes (9:55 PM): . Resident was observed lying in bed .patient was unable to stand and weak .patient stated that he was not in any pain, however, was crying. Daughter contacted to translate .Foley drained darkened urine, Fever 100.7 .Patient began to vomit with daughter at bedside . [DATE] (Hospital Records): Recent Selective lab results . Urine Protein (slightly elevated) .Urine Nitrite - Positive! (possible signs of UTI) .Leukocytes 1+! (signs of infection) .Urine Blood 3+! (possible indication of UTI) .Urine Appearance - Cloudy .Urine Bacteria 1+ (possible signs of UTI) .Urine WBC (white blood count) , d+[DATE]! (possible signs of UTI) .Continue foley at this time .Vancomycin 750 mg (antibiotic) every 24 hours .Pharmacy will continue to monitor renal function .Follow up with (name redacted) .Specialty: Urology in 1 week .Foley catheter 3 weeks ago with a urinary retention felt to be related to constipation .After having bowel movement and increasing his activities, Foley catheter was removed this morning and awaiting for voiding trial . [DATE]: Nursing Summary (Late Entry): Resident readmission .Foley catheter was discontinued in hospital for trial period on discharge date . Observed with condom catheter . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at approximately 10:36 AM, an interview and record review were conducted with the Director of Nursing (DON) and NP 'D. The DON was asked as to the facility's protocol for caring for residents with foley/urinary catheters. The DON reported that if a resident enters the facility with a catheter, they review their records to determine the purpose as to why they have a catheter. Depending on the resident's diagnosis, attempts are made to remove it to encourage continence and avoid the possibility of a UTI. The DON was not able to provide a time as to when and how often those attempts are made. The DON was asked how the facility ensures that catheter care is being completed daily. The DON reported that the CNAs and/or the Nurses follow an order and document in the resident's charts. Both the DON and NP D were asked as to why R904 and R905 did not have any I/Os recorded in their charts as it was noted to do so in their record. The DON reported that despite the notes in the residents' charts, I/O's are not done without a physician's order. The DON was further asked why R905 again had several notes indicating their I/O should be recorded and additionally their Kardex documented it should be done for output. The DON reported that generally the CNAs empty resident's catheter bags and if there is an issue they will tell the nurses but again noted nursing staff do not generally report I/O in their records. The DON could not give an explanation as to why the Kardex noted it should be done. When asked if attempts had been made to discontinue the R905's catheter, the DON reported that they would not do so until the resident was seen by a urologist and noted that the resident is scheduled to see them tomorrow ([DATE]). On [DATE] at approximately 12:20 PM, a request was made to interview the facility's Infection Control (IC) Nurse. The DON reported that the IC Nurse was out of the building and not available for interview. The DON was further interviewed regarding R904 and R905. With respect to R904, the DON was asked why the resident, who on [DATE] the NP noted hazy yellow sediment in their urine and documented a UA order was placed had not yet received had any lab work. The DON reported that while it was documented in the notes, they were waiting for the lab order and believed it would be done today. With respect to R905, the DON was asked as to whether attempts were made to remove the resident's catheter as they had seen their urologist on [DATE]. The DON reported that they were incorrect and R905 had not been seen by the urologist and believed they were scheduled to see the physician tomorrow ([DATE]). The facility policy titled, Indwelling urinary catheter (Foley) care and management -critical Notes ([DATE]) was reviewed and noted, in part: .The Centers for Disease Control and Prevention (CDC) estimates 15% to 25% of hospitalized patients have an indwelling urinary (Foley) catheter .Catheter insertion for inappropriate indications is common Appropriate indications for catheter use include: perioperative use for surgical procedures .Prolonged surgery .surgery requiring large-volume infusions or diuretic use .continuous bladder irrigation .Administration of drugs into the bladder .intraoperative urine output monitoring .prolonged immobilization .need for accurate hourly urine output .acute urinary retention or urinary obstruction . assistance healing of open pressure injuries .improved comfort during end-of-life care .inappropriate or unnecessary use of an indwelling urinary catheter can result in catheter-associated urinary tract infection . Clinical alert: Clean the periurethral area carefully .inspect .the area for signs of inflammation and infection . Assess the securement device daily .Clinical alert .Monitor intake and output, as ordered. Monitor of changes in urine output, including volume and color .Empty the drainage bag regularly when it becomes one-half to two thirds full .Documentation: Documentation associated with indwelling urinary catheter care and management includes: indication for continued catheter use, maintenance care, assessment findings .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235733	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Troy	2685 West Maple Road Troy, MI 48084

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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 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** 34275 This citation pertains to Intake(s) #: MI00151883 and MI00153034. Based on observation, interview and record review the facility failed to maintain complete and accurate electronic medical records for two (R904 and R906) out of six residents reviewed for medical records. Complaints were filed with the State Agency (SA) that alleged residents were not receiving Activities of Daily Living (ADL)/Shower Care on a regular basis and not receiving medication timely. R904 On 5/13/25 at approximately 12:08 PM, R904 was observed sitting in a wheelchair. Their hair appeared greasy, and they had long nails. The resident was alert and able to answer most questions asked. When asked if they received ADL care including nail and shower/bath care, R904 reported that they have not received a shower since being admitted to the facility at the end of April 2025. R904 reported that they do not like showers but needed to have their hair washed and agreed that their nails were long. A review of R904's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Intussusception (a form of bowel obstruction where one segment of the intestine folds inside another), type II diabetes, and acute respiratory failure. A review of the resident's Minimal Data Set (MDS) assessment noted the resident had a Brief Interview for Mental Status (BIMS) score of 13/15 (cognitively intact). A review of R904's TASK record (past 30 days) documented the following: TASK - Shower/Bathing (Did the resident receive a shower/bath/bed bath?)No Data Found TASK - Manicures(nail care): No Data Found A review of R904's care plan on 5/13/25 showed no documentation pertaining to ADL shower/bathing and nail care. On 5/14/25 at approximately 1:26 PM, a request was made for all shower/bath sheets for R904. The Director of Nursing (DON) returned and noted that there was a glitch in recording the day/time the resident received ADL services for showers/baths/nails etc. The DON did report that they spoke with R904 and confirmed that the resident's preference was bed baths. The DON was asked how that was charted and again reported that it was not recorded in the TASK in the bathing/nail section. R906 R906 was admitted to the facility on [DATE] with diagnoses that included: legal blindness, effusion right knee and atrial fibrillation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of R906's clinical record revealed, in part, the following: Nurses Notes (5:29 AM): .Pt (patient) couldn't locate adapter for his phone charger and proceeded to call 911 and tell dispatcher that he was going to kill himself. Police arrived and pt was still upset d/t (due to) missing his missing adapter and making suicidal statements .Patient transferred at approx.(approximately) 5:15 (AM) . Nurses Notes (11:47 PM): Resident contacted 911 .Writer was called to room .Res(resident) stated he would kill himself .Writer asked Res why he would kill himself .Res stated because he wants his meds now Res stated that he does not want to kill himself or anyone else, he is just frustrated because he wants his meds . he apologized and stated he would relax and wait on his medications . (Authored by Nurse I). *It should be noted that there were no notes in the resident's clinical record that indicated what time they returned to the facility on [DATE]. In addition, there were no hospital records or EMS records noted in the resident's clinical record that noted what hospital the resident was transferred to and any accompanying documents. A review of R906's MAR (Medication Administration Record) documented, in part, the following: Amiodarone Tablet: Give one tablet by mouth one time a day for abnormal heart rhythm for 7 days .Start Date: 4/29/25 .Hold date-from 5/1/25 (5:21 AM) to 5/1/25 (8:10 PM). The medication was not administered on 5/1/25. Betamethason Diproprionate External Cream .Apply to Bilateral thighs and Lumbar topically one time a day for dry itchy skin .Start Date: 4/29/25 . Hold date-from 5/1/25 (5:21 AM) to 5/1/25 (8:10 PM). The medication was not administered on 5/1/25. Lidoderm Patch 5% .Apply to R (right) knee topically in the morning for R knee pain and remove per schedule .Start Date: 5/1/25 6:00 AM . Hold date-from 5/1/25 (5:21 AM) to 5/1/25 (8:10 PM). The medication was not administered/removed on 5/1/25. Metoprolol Succinate give 50 mg by mouth one time a day CHF (congestive heart failure) Give by mouth one time a day for 7 days .Start 4/29/25 . Hold date-from 5/1/25 (5:21 AM) to 5/1/25 (8:10 PM). The medication was not administered on 5/1/25. On 5/15/25 at approximately 11:30 AM, a phone interview was conducted with Nurse I. Nurse I was asked about R906, specifically as to concerns noted on 5/1/25. Nurse I recalled that R906 was sent to the hospital after stating he would kill himself but noted they were not present at the time he was transferred to the hospital. Nurse I stated that the resident came back on the same day (5/1/25) but was not able to recall what time he arrived back at the facility and could not recall if his medication was given. On 5/15/25 at approximately 1:00 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked as to the incident that occurred on 5/1/25 and if they were familiar with when the resident left the facility, where they went and when they returned as nothing was noted in the resident's record. In addition, the DON was asked why the resident's medication was not provided on 5/1/25. The DON reported that often documents do not come back with residents who go off to the emergency room and was not able to provide further information. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Electronic Medical Records (1/31/22) was reviewed and documented, in part: Policy: Electronic records are an acceptable format for medical record management .An Electronic Medical Record (EMR) is a completion of information about an individual guest/resident's health status and health care .A EMR is a guest/resident that is created or recorded by computer or other electronic devices .The electronic medical record is defined as containing the following items: .The profile/admission record .Active, discontinued and completed physician orders .Medication and treatment administration records .MDS records .Interdisciplinary progress notes .Care plans .Any document that has been scanned and attached to the guest/resident's electronic medical record (i.e. physician consults, laboratory and diagnostic reports, history and physicals) .Scanned documents .may include documents received from the hospital but should only include the following items: Physician History and Physical .Transfer/Discharge instructions .