STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235236	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burcham Hills Retirement Center	2700 Burcham Drive East Lansing, MI 48823

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 2987836. Based on interview and record review, the facility failed to monitor and address a significant weight gain and increased edema in one (R1) of three reviewed resulting in unrecognized worsening of edema, significant weight gain, loss of consciousness, and hospitalization. Findings include:In a telephone interview on 4/23/26 at 12:13 PM, R1's Significant Other (SO) I reported earlier in the week, prior to R1 transferring to the hospital, they noticed R1 had increased edema in his legs and reported R1 mentioned an increased difficulty in breathing. SO I reported they believed the increased edema was not being addressed. SO I reported R1 remained in the hospital as of 4/23/26. Review of the medical record revealed R1 was admitted to the facility on [DATE] with diagnoses that included atrioventricular block, bradycardia, acute respiratory failure with hypoxia, congestive heart failure (CHF), and atrial flutter. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/31/26 revealed R1 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R1 had an activated Durable Power of Attorney for health care. Review of Hospital notes dated 3/23/26 revealed R1 had acute congestive heart failure. Review of the Clinical admission dated 3/24/26 revealed R1 had non-pitting edema to his right and left palms. There was no mention of lower extremity edema. Review of the Physician's Order dated 3/24/26 revealed R1 was prescribed Furosemide (diuretic medication) 20 milligrams (mg) two times a day for hypertension (high blood pressure). The order was re-written on 4/3/26 to change the timing of the Furosemide, but the dosage remained the same. Review of the Physician's Order dated 3/24/26 revealed an order for weekly weights every Wednesday evening shift. Review of R1's diuretic care plan included an intervention dated 3/24/26 that revealed weigh resident weekly and as needed. Review of the Physician H&P (History and Physical) dated 3/25/26 revealed Problem List .CHF. Review of the Dietary/Nutrition Evaluation dated 3/31/26 revealed R1 had impaired nutrient utilization related to altered sodium and fluid balance secondary to congestive heart failure.Continue to monitor weight trends. Review of the Treatment Administration Record (TAR) revealed on 3/25/26 R1 had two weights obtained which were 221 pounds and 223 pounds. Review of the Weekly Weight Task revealed one weight documented on 3/28/25 which was 215.6 pounds. The next weights were scheduled for 4/1/26, 4/8/26, and 4/15/26 but were not documented as completed on the TAR. The weight box on 4/15/26 was coded as 09-Other/See Nurse Note. Review of the Nurse Notes revealed no documentation as to why the weights were not obtained. Review of R1's Vitals Summary revealed the following weights documented:3/24/26= 223 pounds3/26/26= 221 pounds3/28/26= 215.6 pounds4/10/26= 249 pounds (13 days since previous weight; gain of 33.4 pounds) Review of the Physician Visit Note dated 4/6/26 and documented by Nurse Practitioner (NP) J revealed Weight loss: Weight decreased from 223 lbs at admission to 215.6 lb.Request repeat weight to confirm trend and accuracy. (Of note, the weight of 215.6 pounds was obtained on 3/28/26). A reweight was not documented in the medical record. The next weight was documented on 4/10/26 at 249 pounds, which was a gain of 33.4 pounds. Review of the Physician Visit Note dated 4/13/26 and documented by NP J revealed no mention of R1's most recent weight or the significant weight gain. Review of the N Adv Skilled Evaluation note dated 4/6/26 revealed no edema present. Review of the (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	Physician Progress note dated 4/6/26 and documented by NP J revealed Physical Exam.Extremities: no edema. Review of the N Adv Skilled Evaluation note dated 4/8/26 did not mention edema. Review of the N Adv Skilled Evaluation dated 4/9/26 revealed no edema present. Review of the N Adv Skilled Evaluation note dated 4/10/26 revealed R1 had +1 pitting edema to the left lower extremity and the right lower extremity. The edema was documented as unknown if this was a new onset. The N Adv Skilled Evaluation dated 4/11/26 revealed R1 had 1+ pitting edema to the right and left lower extremities. The edema was documented as unknown if this was a new onset. The N Adv Skilled Evaluation note dated 4/12/26 revealed R1 had 2+ pitting edema to the right and left lower extremities. The edema was documented as unknown if this was a new onset. The N Adv Skilled Evaluation dated 4/13/26 revealed R1 had 2+ pitting edema to the left lower extremity and 1+ pitting edema to the right lower extremity. The edema was documented as unknown if this was new onset. According to the Cleveland Clinic, Pitting edema is a type of swelling where pressing on a swollen body part leaves behind a dent or pit that takes time to refill. The deeper the dent and the longer it takes to refill, the more severe this swelling is .Edema grading uses a scale to check how severe pitting edema is. The grading also lets providers estimate how much fluid has built up in your tissues. To find the grade, they'll use a pitting test. To do this test, they'll gently press their finger on a swollen area of your skin for five to 15 seconds. If you have edema, a pit or dimple will remain on your skin when they pull their finger away. They grade edema based on how deep the pit goes and how long it takes for the pit to fill in (rebound) and return to being flat skin.The grades are:Grade 1 [1+]: Immediate rebound with a 2 millimeter (mm) pitGrade 2 [2+]: Rebound in under 15 seconds with a 3 to 4 mm pitGrade 3 [3+]: Rebound in between 15 and 60 seconds with a 5 to 6 mm pitGrade 4 [4+]: Rebound within two to three minutes with an 8 mm pitThe pitting test only works if you have pitting edema. It's also possible to have nonpitting edema. (https://my.clevelandclinic.org/health/symptoms/pitting-edema) Review of the Progress Note dated 4/17/26 at 2:09 AM revealed Res [Resident] stated this evening he is in congestive hear [heart] failure. Dtr [daughter] stated he has a dx [diagnosis] of CHF.Res also expressed concern about tibia edema not resolving or getting worse. Review of the Progress Note dated 4/17/26 at 9:32 AM revealed R1 was sent to the Emergency Department related to loss of consciousness and hypoxia. Review of the Physician Visit Note dated 4/17/26 at 9:46 AM and documented by NP J revealed Chief Complaint: Loss of consciousness.history of congestive heart failure.concern that heart failure is worse due to persistent and worsening lower-leg swelling.reports tibial edema progressing.Assessment & Plan: 1. Acute respiratory distress: Patient developed respiratory distress in bed; EMS called, placed on non-rebreather with edema present.Congestive heart failure with worsening lower-extremity edema : Patient reports progressive tibial edema despite furosemide 20 mg twice daily.edema noted on exam. Concern for fluid overload contributing to symptoms. Most likely form recent abdominal CT with contrast causing fluid overload. In a telephone interview on 4/23/26 at 2:48 PM, Registered Nurse (RN) H reported they were a dayshift nurse and were not responsible for conducting assessments on odd number rooms. RN H reported night shift assessed odd number rooms and dayshift assessed even number rooms. RN H reported they never assessed R1's edema but received in report that R1 had edema without any changes. When asked if they were aware that R1 had a significant weight gain, RN H reported they didn't look at his weight. RN H reported if there is a weight increase of 3 pounds in one day or 5 pounds in one week, the physician should be notified. In a telephone interview on 4/24/26 at 7:43 AM, Licensed Practical Nurse (LPN) G reported they thought R1 was admitted with 2+ pitting edema to both legs, but could not recall. LPN G reported the night before R1 was sent to the hospital, he was anxious and R1's family mentioned the edema in his legs might be bigger. LPN G reported they believed R1 was weighed weekly but did not know if R1 had any weight changes. LPN G reported they did not know R1 had CHF because they did not see the diagnosis in the medical record. LPN G reported residents with a diagnosis of CHF were supposed to be weighed daily and the physician should be notified if there is a weight gain of 3 pounds in one day (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	or 5 pounds in one week. In an interview on 4/24/26 at 10:48 AM, NP J reported R1 had CHF. When asked about monitoring a resident with CHF, NP J reported it depended on how stable the resident was; often weights were daily, sometimes weekly. NP J reported the weights were the major thing and edema would be another thing to monitor. NP J reported they assessed R1 on 4/6/26 and no edema was present. When asked about her note on 4/6/26 that indicated a reweight was requested, NP J reported they would expect that reweight to be done the next day or the day after. NP J reported they were not notified of R1's 33.4# weight gain but would be expected to be notified. NP J reported she was not aware of R1's weight gain when she assessed R1 on 4/13/26 but wished she would have been aware so that she could have obtained a reweight. In an interview on 4/24/26 at 11:09 AM, Director of Nursing (DON) B reported if a resident admitted with a CHF diagnosis, the facility started with daily weights on admission. DON B reported nursing was responsible for monitoring weights and reporting to the physician if there was a 3-pound gain in one day or a 5-pound gain in one week. DON B reported R1 did not have an order for daily weights but instead had an order for weekly weights. When asked if the weekly weights were completed, DON B reported it appeared the weights were obtained every two days to start and then there was a two-week gap with a big jump in R1's weight. DON B reported they received an email on 4/14/26 from the dietitian requesting a reweight of R1 but did not see the reweight in R1's medical record. DON B reported reweights should be obtained within 24 hours of being requested. DON B reported they would have expected staff to notify the provider of R1's weight gain of 33.4 pounds and also the change in edema. DON B reported they reviewed R1's progress notes from the night before hospitalization and had requested the team to have the provider (physician/NP) follow up because R1 seemed to have a change in condition with his anxiety.