STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235354	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Health and Rehabilitation	55378 Wilbur Rd Three Rivers, MI 49093

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** 38384 This citation pertains to intakes MI00142592 and MI00142727. Based on interview and record review, the facility failed to assess an acute change of condition in 1 of 4 residents (R102) and failed to provide appropriate skin care for open wounds in 1 of 4 residents (R103) reviewed for quality of care, resulting in a delay in assessment, treatment and subsequent hospitalization for for dehydration and hypernatremia (elevated sodium) for R102 and the potential for infection for R103. Findings include: According to the Minimum Data Set (MDS), [DATE], R102 was reported to have a memory problem with her cognitive skills for daily decision making severely cognitively impaired with a BIMS (Brief Interview Mental Status) score of ,d+[DATE]. Her diagnoses included Alzheimer's disease, dementia, and adult failure to thrive. Review of R102's Order Summary [DATE]-[DATE], reported for 14-days, the resident was placed on droplet isolation and was to remain in room with the door closed for Covid-19 exposure. Review of R102's Advance Directives, [DATE], revealed: -Do Not wish to have Cardiopulmonary Resuscitation (CPR) -I Do wish to be hospitalized -I Do wish to IV hydration fluid (Intravenous placement) along with IV antibiotic treatments if necessary -I Do want medication for comfort During an interview on [DATE] at 2:15 PM, Certified Nursing Assistant (CNA) E stated, (R102) is pleasantly confused and will talk to you but she may not be able to answer your questions. She can have nothing in her mouth to eat or drink. It is kind of sad because she liked to drink water before she went to the hospital. She would drink water, but staff had to urge her to drink. Staff was to offer her water when they did her check and change every 2 hours. I do not know if it was documented every time she drank or how much. (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	In an interview on [DATE] at 11:26 AM, Registered Nurse (RN) F stated, I worked on [DATE] but not River Unit (R102's). My aide (CNA) came back from River and told me (R102) was dying. I as in shock because I had seen no indications the last day, I worked with her. I went right over to that unit and observed (R102) trying to talk and could not talk. Her left hand was shaking. I went to talk to her nurse, (LPN G), who told me the resident was dying. (LPN G) told me she called the son who was coming but had not called the physician to tell him about the change in condition or ask for orders. I called the physician for Roxanol (morphine sulfate for treating severe, chronic pain) because the resident looked scared with possible stroke-like symptoms. I did not know what she had done for (R102). I do not know if vitals or an assessment was done. I went back to my unit and waited for the physician to call back. When the physician did call back, he wanted to talk to (LPN G). She had difficulty understanding the electronic process for paperwork. It was overwhelming for her. I had helped her out numerous times. I was there when the physician called and put him on speaker. (LPN G) said (R102) was DNR and the physician asked if she was able to be hospitalization . (LPN G) told him No. I saw the paperwork and (R102) wished for hospitalization . Family got to the facility around 7:30 PM. The son, (Family Member (FM) H) knew me from me working with (R102). I was paged numerous times by the on-coming nurse (LPN J) about what was happening with (R102). She only got report from (LPN G) that (R102) was dying. When the order came from the physician for Roxanol, I got the code to get it out of the Cubex (controlled substance storage). I pulled it and gave it to (LPN J). she said I had a better repoire with the family and wanted me to go to (R102's) room. (LPN G) was at the desk supposedly doing medication count and end of shift paperwork. I talked to the resident's family and they wanted to know why (R102) had not been seen by a physician and was not sent out to the hospital. I did not know because I was not her nurse, (LPN G) was. The family requested (R102) to be sent to the ER, I told (LPN G). (LPN J) and I started the transfer paperwork. (LPN G) did not help with the transfer. (LPN J) called the physician to tell him and then called the hospital to give report. When the EMTs (Emergency Medical Technician) came to transport (R102), they asked me why she was being sent out. I told them I thought (R102) was having a stroke. The EMTs asked why the resident was not sent out earlier if the signs/symptoms had started around 4:00 PM and it was now around 7:45 PM. (LPN G) sat observing this and did not help. She said (R102) was a DNR and did not need to go to the hospital. After (R102) had been sent out, her CNAs told me they had told (LPN G) (R102) had not been drinking or talking. On Monday, [DATE], I told the Nursing Home Administrator (NHA A) and the DON (Director of Nursing B) what happened. I also told them (LPN G) did not listen to CNAs when they told her residents had a change in condition or needed something. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:18 PM, CNA K stated, I was working on the unit with (LPN G and R102) on February 3rd ([DATE]). I got report from another CNA that R102 was acting off all week. On [DATE] (R102) was not very talkative and did not want to eat or drink. She was out of it like sitting and staring off. Usually, she is pretty alert and waves at you. She is 1 person assist and will help you roll and turn. She was not able to help on [DATE]. (LPN G) was her nurse on ,d+[DATE] and did not assess on (R102) when I told her about the change in behavior. (Unit Manager (UM) D) was working as a CNA on the unit and I told her (R102) did not want to eat or drink or help move. When I was in the dining room that weekend and told four different nurses including (LPN G, UM D, and LPN J) them all about (R102) acting differently. When I came in on [DATE] in the morning, the report said (R102) was acting kind of off, that she was worse. She was not making sense when she talked and was lethargic. Staff would do tactical touch, like touch her arm with no response. She was making funky sounds like maybe some fluid was in her upper chest. You could hear it from the bedside. She did not eat, drink or help roll. I went and found (LPN G) at the desk and I told her specifically (R102) was not doing well. First thing that morning she was worse than the day before (, d+[DATE]) but by afternoon that day (,d+[DATE]) she was total care. (LPN G) did not get up to look at (R102). She not seemed concerned. (CNA L) came on shift around 3 pm and saw (R102) and called me to come look at her. She was concerned and told (LPN G) (R102) had been like that all weekend. (CNA L) kept telling (LPN G) that (R102) looked like she was dying and finally got (LPN G) to look (R102). After (LPN G) could not get (R102) to respond to her she went to her med cart and asked me what to do. (RN F) came over from another unit and decided to look at the resident then called the physician and was waiting for the physician to call back. (LPN G) did not take vitals or ask one of us CNAs to do them. The family came and were upset that the decision to have (R102) sent out was not made. In (R102's) chart it said she wanted hospitalization and was not sent to the hospital until the family insisted. During an interview and record review on [DATE] at 3:01 PM, LPN/Unit Manager (UM) D stated, I am the UM for (R102's) unit. I worked on the unit as a CNA on Saturday [DATE] and assisted (R102) to eat breakfast. She did decent with eating maybe 50% of meal and drank 2 cups of liquid. There was no change in her normal condition. That was about 8:30 am ish. I do not recall anyone saying anything to me about her having a change in condition. I worked primarily the back section of that hall and not really with (R102) except for meals. (LPN G) was the nurse on that day. When a resident has a change in condition, the nurse should do an assessment and call the physician. (LPN G) did not do that with (R102) on that day ([DATE]), she waited until another nurse came from another unit to see what was going on. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 8:05 AM, LPN J stated, I work the night (NOC) shift 7 PM to 7 AM on [DATE] and [DATE]. I did not notice any change of condition for (R102) on [DATE]. An aide did tell me (R102) was not wanting to eat, but she took her medications from me, and I did not think anything of it. When I started my shift on [DATE], I walked past (R102's) room and saw her with a washcloth on her forehead and family around her. She was unresponsive. I thought what the heck is going on with her. It was a shock to see the family in the room. I took report from (LPN G). RN F came over from another unit, telling me she was going to call the doctor for (R102) then come back. After report with (LPN G) we were counting medications at the med (medication) cart when (RN F) came back. The family was still in the room. One of the sons was talking on the phone with another son. The son that was on the phone and not in the room wanted (R102) sent to the ER (emergency room). I was confused about everything that was going on. I thought why was this going on now, when I was told (R102) had this change in condition earlier in the day. Why wasn't something done earlier? I asked (RN F) to help with the transfer paperwork even though (LPN G) was still at the nursing station. I pulled (R102's) advanced directives to see if she could go to the hospital because (LPN G) told me the resident was dying. Plus, the doctor would want to know code status and if it was the resident's wishes to be sent to the hospital. The doctor was called and said it was okay to send (R102) to the hospital. (RN F) and I got paperwork around and sent the resident to the hospital. (LPN G) was upset because she said (R102) was to be DNR, but the Advanced Directives stated she could to the hospital and that is what her representative said to do. During an interview on [DATE] at 11:31 AM, Nursing Home Administrator (NHA) A stated, On February 4th (2024), (R102) had a change in condition and (LPN G's) initial observation led her to believe the resident was passing and that is what she reported to the family and medical director. Initially, I as was not aware of any concerns. (FM H) arrived at around 5 PM that evening and shortly after 7 pm they were sending the resident to the hospital. The following morning (FM I) called me with concerns that his mother had not been seen by a physician or sent to the hospital earlier. It was (LPN G's) attention to (R102's) change of condition that was the concern. During an interview on [DATE] at 12:18 PM, FM I stated, On February 4th (2024), I got a call saying the facility was preparing my mother for end-of-life from my brother. I asked questions and found out she was not seen by a doctor, only the nurse. I wanted mother to see a doctor so the facility transferred her to the ER. There, they found she was severely dehydrated and had a UTI. She was transferred to from there to a larger hospital. They found my mother had a swallowing issue. I spoke to the facility Administrator who told me they felt the incident was mishandled because of the lack of all-around medical treatment and mother should have seen a doctor before telling us she was dying. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:36 PM, FM H stated, I got a call on February 4th (2024) from (LPN G) that my mother was dying. I wondered why they did not call earlier since she was a DNR and could go to the hospital. When I got to the facility, (LPN G) told me mother was dying and there was no point in doing anything for her. I asked if the facility had called an ambulance. (LPN G) tried repeatedly to talk me out of sending my mother to the hospital because nothing could be done for her she thought. Another nurse told me she thought my mother had a stroke. (LPN G) was was so frazzled I called all my relatives telling them mom was dying. I got ahold of my older brother, and he said to get her to the hospital immediately. (LPN G) was wondering why I would have her sent to the hospital when mother was DNR. Turns out mom was severely dehydrated. Mom had a problem with her throat and was not eating or drinking much. She perked up right away when the ER gave her fluids then shipped her to another hospital. There, they found she had a kidney infection from built up of salt in her system which took two weeks to stabilize. The facility was not keeping her hydrated. I was told by the facility's Administrator and Director of Nursing that I should not have been told by (LPN G) my mother was dying. My concern was the medical issue that (LPN G) basically ignored because she though my mother was dying and not wanting to send her to the hospital. Seems like the facility should have known mother was not eating and drinking and she had dehydration and a bad kidney infection. Review of R102's Progress Note dated [DATE] at 17:38 (5:38 PM), reported LPN G was notified at 4:11 pm by a CNA that R102 was not looking well. When the LPN entered the resident's room it was noted the resident was cyanotic (bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation of the blood), eyes sunken, warm to the touch, right hand shaking, and not responding to verbal stimulation. Unable to get vital signs. Family Member (FM) H arrived at facility at 5:15 PM. Review of R102's Progress Note dated [DATE] at 20:47 (8:47 PM), reported LPN J entered the resident's room at 7:05 PM to administer PRN (as needed) morphine sulfate. Family stated they wanted the resident to be sent to the hospital. The LPN notified the facility's physician, received an order to send R102 to the hospital. R102 left the facility at 7:58 PM with EMS (emergency medical services) to a local hospital. Review of R102's Medical Record Control Report dated [DATE] at 2016 (8:16 PM), reported the resident was seen at the ER as a priority 1, with a blood pressure (BP) reading of ,d+[DATE] (normal readings lower than , d+[DATE]), Pulse 140 (normal readings lower than 70 beats per minute), stroke-like symptoms since 4 pm, pinpoint pupils, was not alert and oriented with minimal responses. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R102's ED (emergency department) Summary Report dated [DATE], revealed on [DATE] at 20:24 (8:24 PM) after receiving fluids during transfer, the resident's vital signs were BP ,d+[DATE], P 80, respirations (R) 24, and oxygen saturation (PO2) 96% on room air (RA). History of present illness .altered mental status (AMS) . was sent in for evaluation for a possible stroke because she was not responding appropriately and had sunken in eyes. Upon arrival she was able to respond to simple yes or no questions, follow minimal commands, and appeared to be following in conversation .Initial concern was for patient nearing the end of her life as patient is a DNR and had been steadily declining since being at her rehab facility. This was also the impression given to hospital by staff at the nursing home. However, upon speaking to family, they stated that this shift in her condition was sudden over the past few days. Due to this, further workup was performed. Workup was notable for a leukocytosis (high white blood cell count), significant hemoconcentration (abnormally high concentration of blood, thickened or concentrated) likely due to dehydration (caused by not drinking enough fluid or by losing more fluid than you take in). AKI (acute kidney injury) (abrupt decrease in kidney function) is present with a creatinine of 3.4 (0.97 near normal in elderly) and GFR (glomerular filtration rate) (chief measure of kidney function) of 13, (near normal 75) with no reported history of kidney disease. Patient was noted to be significantly hypernatremic (lower level than normal sodium in blood caused by limited fluid intake, presents as confused and fatigued, and requires hospitalization) at 166 (normal ,d+[DATE]), with an elevated chloride of 124 (normal ,d+[DATE]) (sign of dehydration), and elevated serum osmolality at 343 (normal ,d+[DATE]) (sign of dehydration. Patient was straight cathed for a urine sample and was found to have extremely concentrated urine with evidence of an infection (UTI) .Foley catheter was inserted to accurately monitor urine output . Patient was transferred in stable but critical condition to (name of larger acute care hospital) ICU (intensive care unit) .Diagnoses included dehydration, AMS, AKI, acute UTI. This surveyor attempted to interview Licensed Practical Nurse (LPN) G on [DATE] at 10:17 AM but was unable to leave a voicemail due to it being full. R103 According to the Minimum Data Set (MDS), R103 scored 4 /15 (severely cognitively impaired) on his BIMS (Brief Interview Mental Status), with diagnoses that included metabolic encephalopathy and need for assistance with personal cares. Review of R103's Incident Report (IR) dated [DATE] at 5:45 AM, indicated the resident was found in his room lying on the floor next to his bed. No injuries reported at that time. Review of R103's IR dated [DATE] at 06:00 AM, indicated the resident was found in his room sitting on the floor in front of a couch. A skin tear 2 x 2 cm (centimeters) was noted on his right lower leg/shin. First aid was applied to the right shin. Review of R103's Order Summary, dated [DATE], indicated two abrasions to the resident's right lower leg was to be cleaned with normal saline, patted dry, with triple antibiotic ointment applied then covered with a border foam dressing every other day and as needed. Monitoring for infection every 2 hours. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R103's Order Summary, dated [DATE], indicated a new right shin skin tear to the resident's right shin that was to be cleaned with normal saline, patted dry, with mepiplex (absorbent dressing) applied every other day on the evening shift. It was noted an addendum to the Order Summary was added also on [DATE] to monitor the new skin tear to right shin daily for signs and symptoms of infection on every shift. Review of R103's Order Summary, dated [DATE], indicated a new skin tear to the resident's right shin that was to be cleaned with normal saline, patted dry, and covered with a comfort foam dressing every other day and as needed. Monitoring for infection was to be done every 24 hours. Further review of R103's Order Summary did not indicate or contain physician's orders for skin tears, abrasions, or wounds to the resident's left leg. Review of R103's Medication Administration Record/Treatment Administration Record (MAR/TAR) dated [DATE]-[DATE] indicated: -[DATE] Cleanse abrasions x2 to the RLE (right lower extremity) with NS (normal saline), pat dry, apply TAO (triple antibiotic ointment) and comfort foam drsg (dressing) every other day and as needed ([DATE]). Monitor for infection every day shift every other day. Start date [DATE] 0700 (AM). It was noted this was placed on the MAR/TAR two days after the physician's order was obtained. Review of R103's MAR/TAR dated [DATE]-[DATE] indicated: -Cleanse NEW R (right) shin ST (skin tear) w/NS (with normal saline), pat dry, apply comfort foam drsg every other day and as needed. Monitor for infection every evening shift every other day for wound care. Start date [DATE] 1900 (7 PM). It was noted, the order was not documented as being completed on [DATE]. Review of R103's MAR/TAR dated [DATE]-[DATE] indicated: -Skin Assessment weekly on Saturday every day shift every Saturday. Start date [DATE] 0700. It was noted this was documented as being completed on [DATE] and [DATE] with only vital signs being entered. Review of R103's Care Plan, dated [DATE], indicated the focus of Potential Skin Breakdown related to fragility of skin and multiple abrasions. The goal was for current abrasion to heal without complications. To meet this goal, interventions included providing treatments to abrasions as ordered. Observed on [DATE] at 11:22 AM, R103 with 2 border-form dressings on both shins, dated ,d+[DATE]. Observed on [DATE] at 9:08 AM, R103 with 2 border-form dressings on both shins, dated ,d+[DATE]. Observed on [DATE] at 8:20 AM, R103 with 2 border-form dressing on both shins, dated ,d+[DATE]. During an observation and interview on [DATE] at 8:30 AM, Registered Nurse (RN) C entered R103's room with surveyor and looked at the resident's shins. On each of his shins, right and left, were two border-foam dressings labeled ,d+[DATE]. RN C stated, Today's date is ,d+[DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During observation, interview, and record review on [DATE] at 8:35 AM, Unit Manager (UM) D entered R103's room with surveyor. UM looked at the resident's shins stating, (R103) has two border-foam dressings on each shin that are dated ,d+[DATE]. The UM stated, ,d+[DATE] was three days ago. After leaving the resident's room, UM reviewed R103's medical record, Order Summary and MAR/TAR, stating, (R103) does not have an order for the two dressings on his left shin. Nurses will not know to monitor and change the dressing if the treatment order is not put in the MAR. UM D further reviewed the Order Summary and MAR/TAR stating, (R103) should have his dressing changed on his right shin every other day. It does not state on what shift. If a time is not indicated on an order, the treatment may get missed and the wound could get worse.