

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Edgewood Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999</p> <p>Based on interview and record review, the facility failed to immediately report an elopement and submit an investigation report to the State Agency within 5 days, for one resident (Resident #100) of three residents reviewed for abuse, from a total sample of 4 Residents, resulting in an elopement being unidentified or properly investigated, and the potential for continued elopements to go unreported and thoroughly investigated.</p> <p>Findings include:</p> <p>Review of the facility's Elopement and Wandering Residents policy with a reference date of 1/24 revealed: Definition: Elopement occurs when a resident leaves the premises without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Section 5 titled Procedure for Locating Missing Resident item g. stated: Appropriate reporting requirements to the State Survey agency shall be conducted.</p> <p>Resident #100</p> <p>Review of an Admission Record revealed Resident #100, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia, cognitive communication deficit, muscle weakness, and other specified disorders of bone density and structure (condition causing a decrease bone mineral density and bone mass).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 3/2/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #100 was severely cognitively impaired. Section E of the MDS revealed Resident #100 experienced delusions (misconceptions or beliefs that are firmly held, contrary to reality).</p> <p>Review of an Elopement Risk assessment for Resident #100 with a reference date of 12/27/23, revealed the resident was deemed high risk for elopement.</p> <p>Review of a Complaint Investigation Report dated 5/21/24, revealed an anonymous allegation that Resident #100 exited the facility unsupervised on 5/15/24.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/12/24 at 10:51am Licensed Practical Nurse (LPN) M reported she arrived at the facility sometime after 6pm on 5/15/24 and noticed an elderly man walking alone under the overhang near the front door as she pulled in. LPN M reported when she saw the man outdoors, she did not recognize him initially, but the man crossed the parking lot and walked up to her car, which was near the handicapped parking, as she sat talking on her phone. When he got close, she realized the man walking alone in the parking lot was Resident #100. LPN M reported she did not go on duty until 7pm but was concerned about Resident #100's welfare and called the facility to report he was outside unattended.</p> <p>In an interview on 6/13/24 at 10:25am, Certified Nursing Assistant (CNA) Q reported her work shift on 5/15/24 began at 6pm and sometime after that she answered a phone call from LPN M who told her Resident #100 was in the parking lot. CNA Q reported she immediately told Registered Nurse (RN) E, and RN E ran toward the front lobby.</p> <p>In an interview on 6/12/24 at 10:12am, Registered Nurse (RN) E reported around 6:30pm she ran to the front parking lot and found Resident #100 walking around. Resident #100 stated I'm looking for my car and my wife. All I need is my keys.</p> <p>In an interview on 6/13/24 at 8:03am Licensed Practical Nurse (LPN) F reported Resident #100 was standing in the parking lot with several staff around him when she arrived at the facility on 5/15/24, sometime before 7pm. LPN F reported she approached Resident #100 at which time he indicated he was trying to leave and appeared confused and lost. LPN F reported Resident #100 was disoriented at his baseline level of cognitive functioning and could not make decisions regarding his own safety. LPN F reported Resident #100 frequently wandered around the facility in his wheelchair, voiced a desire to leave and had not walked for a long time because he had a fall. LPN F reported it was not safe for Resident #100 to exit the building alone because of his cognitive deficits, his decreased mobility in the past year, and his history of falls.</p> <p>In an interview on 6/13/24 at 11:02am, Licensed Practical Nurse (LPN) Nursing Supervisor (NS) J reported an investigation should be completed after a cognitively impaired resident leaves the building without authorization because the facility must identify hazards and put interventions in place to reduce the likelihood of future elopements.</p> <p>In an interview on 6/13/24 at 11:21am, Director of Nursing (DON) B reported the facility decided Resident #100's unsupervised exit of the building, into the parking lot, did not constitute an elopement and thus, the incident was not reported to the State Agency and no further investigation was conducted. When further queried, DON B agreed that Resident #100 did not have authorization to leave the building alone and he was not directly accompanied by a staff member despite his need for assistance to safely ambulate. DON B confirmed the facility could not verify Resident #100's whereabouts on 5/15/24 from 5:00pm-6:29pm.</p> <p>In an interview on 6/13/24 at 12:00pm, Medical Director (MD) V reported he wrote physician orders for residents who were safe to exit the building without supervision. MD V reported he was not comfortable with severely cognitively impaired residents leaving the building alone and did not provide medical authorization for Resident #100 to do so.</p> <p>Review of Resident #100's physician orders revealed no orders to allow him to leave the facility alone.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999</p> <p>Based on interview and record review, the facility failed to develop a person centered care plan for one resident (Resident #100) of three residents reviewed for elopement, resulting in the resident exiting the building unsupervised, and a potential for the resident to experience more than minimal harm.</p> <p>Findings include:</p> <p>Resident #100</p> <p>Review of the facility's Elopements and Wandering Residents policy, with a reference date of 1/2024, revealed Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . Definition: Elopement occurs when a resident leaves the premises without authorization .or necessary supervision .</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 2: Assessments for the Resident Assessment Instrument (RAI), revealed .the resident ' s care plan must be reviewed after each assessment .and revised based on changing goals, preferences and needs of the resident and in response to current interventions .Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan .</p> <p>Review of an Admission Record revealed Resident #100, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia, cognitive communication deficit, muscle weakness, and other specified disorders of bone density and structure (condition causing a decrease bone mineral density and bone mass).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 3/2/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #100 was severely cognitively impaired. Section E of the MDS revealed Resident #100 experienced delusions (misconceptions or beliefs that are firmly held, contrary to reality). Section GG of the MDS revealed Resident #100 only used a wheelchair for mobility during the 7-day assessment period, and an attempt to assess his ability to walk 10 feet was not made due to his medical status.</p> <p>Review of a Care Plan for Resident #100, with a reference date of 3/28/23 revealed the following pertinent focus/goal/interventions: Focus: Resident is at risk for falls r/t (related to) confusion, balance problems . h/o (history of) falls, osteopenia (loss of bone density) .Goal: The resident will not sustain serious injury . Interventions: Resident is at high risk for falls .room placement close to nurses station . The care plan did not contain a focus/goal/approach related to Resident #100's risk for elopement.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the most recent Elopement Risk assessment for Resident #100 with a reference date of 12/27/23, revealed the resident was deemed high risk for elopement.</p> <p>In an interview on 6/13/24 at 8:03am Licensed Practical Nurse (LPN) F reported Resident #100 was standing in the parking lot with several staff around him when she arrived at the facility on 5/15/24, sometime before 7pm. LPN F reported she approached Resident #100 at which time he indicated he was trying to leave and appeared confused and lost. LPN F reported Resident #100 was disoriented at his baseline level of cognitive functioning and could not make decisions regarding his own safety. LPN F reported Resident #100 frequently wandered around the facility in his wheelchair, voiced a desire to leave and had not walked for a long time because he had a fall. When further queried about Resident #100's elopement risk assessment/score, LPN F reported she did not know because the Nursing Supervisor was responsible for those. LPN F reported it was not safe for Resident #100 to exit the building alone because of his cognitive deficits, his decreased mobility in the past year, and his history of falls. LPN F reported no specific care plan interventions were in place for Resident #100 related to the possibility of him eloping from the building.</p> <p>In an interview on 3/13/24 at 11:02am Licensed Practical Nurse (LPN) Nursing Supervisor (NS) J reported any resident who scored at risk for elopement should have a person-centered care plan to reduce the likelihood of them successfully eloping. NS J reviewed Resident #100's most recent elopement risk assessment and confirmed the resident scored in the high risk range and should have had a care plan to address his needs.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999</p> <p>Based on observation, interview, and record review the facility failed to provide an environment that was free from accident hazards for two residents (Resident #100 and Resident #104) of four residents reviewed for accidents. This deficient practiced resulted in an elopement for Resident #100 and the potential for more than minimal harm, and Resident #104 enduring a head laceration when he fell from mechanical lift that had not been properly maintained.</p> <p>Findings include:</p> <p>Resident #100</p> <p>Review of an Admission Record revealed Resident #100, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia, cognitive communication deficit, muscle weakness, and other specified disorders of bone density and structure (condition causing a decrease bone mineral density and bone mass).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 3/2/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #100 was severely cognitively impaired. Section E of the MDS revealed Resident #100 experienced delusions (misconceptions or beliefs that are firmly held, contrary to reality). Section GG of the MDS revealed Resident #100 only used a wheelchair for mobility during the 7-day assessment period, and an attempt to assess his ability to walk 10 feet was not made due to his medical status.</p> <p>Review of a Care Plan for Resident #100, with a reference date of 3/28/23 revealed the following pertinent focus(s)/goal(s)/interventions: 1. Focus: Resident has .limited mobility .Goal: Resident will have assistance . as needed. Interventions: Resident uses a wheelchair for mobility. 2. Focus: Resident is at risk for falls r/t (related to) confusion, balance problems . h/o (history of) falls, osteopenia (loss of bone density) .Goal: The resident will not sustain serious injury .Interventions: Resident is at high risk for falls .room placement close to nurses station . The care plan did not contain a focus/goal/approach related to Resident #100's risk for elopement.</p> <p>Review of the facility's Elopements and Wandering Residents policy, with a reference date of 1/2024, revealed Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . Definition: Elopement occurs when a resident leaves the premises without authorization .or necessary supervision .</p> <p>Review of a Durable Power of Attorney document with a reference date of 12/5/22 revealed Resident #100 appointed his spouse to make decisions on his behalf effective this date.</p> <p>Review of an Elopement Risk assessment for Resident #100 with a reference date of 12/27/23, revealed the resident was scored as high risk for elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Complaint Investigation Report dated 5/21/24, revealed an anonymous allegation that Resident #100 exited the facility unsupervised on 5/15/24.</p> <p>During an observation on 5/13/24 at 2:45pm, the pavement under the canopy outside the facility's front doors was noted to have a cracked, uneven surface that was 4 wide and more than 5' long. The pavement sloped downward toward the handicapped parking area. The parking lot near the handicapped parking spaces was uneven with sunken portions, cracked asphalt in several areas, and multiple rocks and debris were present as well. The distance between the canopy area and the handicapped parking slots was greater than 50 feet.</p> <p>In an interview on 6/12/24 at 9:11am, Certified Nursing Assistant (CNA) H reported Resident #100 had the ability to walk if a staff member walked with him and directed him while holding his hand, but he did not routinely walk.</p> <p>In an interview on 6/12/24 at 10:03am Certified Nursing Assistant (CNA) P reported he arrived at the facility at 5:00pm on 5/15/24 and saw Resident #100 sitting in his wheelchair in the lobby of the facility. CNA P reported he had cared for Resident #100, was not aware the resident could ambulate but had seen Resident #100 transfer himself from his wheelchair to the bed. CNA P reported he did not see Resident #100 again until later that evening when the resident was returned to the unit by another staff member.</p> <p>In an interview on 6/12/24 at 12:00pm Director of Maintenance (DOM) N reported the facility's lobby doors were supposed to be locked after business hours, but staff members could unlock them and had done so previously when large events occurred.</p> <p>In an interview on 6/12/24 at 10:51am Licensed Practical Nurse (LPN) M reported she arrived at the facility sometime after 6pm on 5/15/24 and noticed an elderly man walking alone under the overhang near the front door as she pulled in. LPN M reported when she saw the man outdoors, she did not recognize him initially, but the man crossed the parking lot and walked up to her car, which was near the handicapped parking slots, as she sat talking on her phone. When he got close, she realized the man walking alone in the parking lot was Resident #100. LPN M reported she did not go on duty until 7pm but was concerned about Resident #100's welfare and called the facility to report he was outside unattended.</p> <p>In an interview on 6/13/24 at 10:25am, Certified Nursing Assistant (CNA) Q reported her work shift on 5/15/24 began at 6pm and sometime after that she answered a phone call from LPN M who told her Resident #100 was in the parking lot. CNA Q reported she immediately told Registered Nurse (RN) E, and RN E ran toward the front of the building.</p> <p>In an interview on 6/12/24 at 10:12am, Registered Nurse (RN) E reported around 6:30pm she ran to the front parking lot and found Resident #100 walking around. Resident #100 stated I'm looking for my car and my wife. All I need is my keys. RN E reported Resident #100 initially refused to go back inside but when Licensed Practical Nurse (LPN) F arrived she was able to persuade Resident #100 to go indoors. RN E reported the front door was unlocked when she exited the building to look for Resident #100 and when they returned inside. When further queried, RN E reported there was a large birthday gathering happening in the conference room just inside the lobby and she wondered if the door was unlocked for that.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/13/24 at 8:03am Licensed Practical Nurse (LPN) F reported Resident #100 was standing in the parking lot with several staff around him when she arrived at the facility on 5/15/24, sometime before 7pm. LPN F reported she approached Resident #100 at which time he indicated he was trying to leave and appeared confused and lost. LPN F reported Resident #100 was disoriented at his baseline level of cognitive functioning and could not make decisions regarding his own safety. LPN F reported Resident #100 frequently wandered around the facility in his wheelchair, voiced a desire to leave and had not walked for a long time because he had a fall. When further queried about Resident #100's elopement risk assessment/score, LPN F reported she did not know because the Nursing Supervisor was responsible for those. LPN F reported it was not safe for Resident #100 to exit the building alone because of his cognitive deficits, his decreased mobility in the past year, and his history of falls.</p> <p>In an interview on 6/13/24 at 8:51am on Family Member (FM) S reported he hosted a birthday party in the conference room near the front lobby doors of the facility on 5/15/24 at 6pm. FM S reported he recalled letting people in and out of the building by entering a code to unlock the doors that day but was not aware a resident was found unattended in the parking lot.</p> <p>In an interview on 6/13/24 at 8:59am Registered Nurse (RN) X reported she responded to the parking lot on 5/15/24 with RN E. RN X reported the front lobby doors were unlocked when she ran out. RN X reported she was concerned for Resident #100's safety because he usually did not walk and had poor safety awareness. RN E reported she had last seen Resident #100 sitting in the lobby at 3pm that day. RN X reported she called Director of Nursing (DON) B immediately and told her Resident #100 was in the parking lot, as other staff attended to Resident #100. RN X reported DON B did not instruct her to proceed with elopement protocol procedures.</p> <p>In an interview on 6/13/24 at 11:02am Licensed Practical Nurse/Nursing Supervisor (NS) J reported when a resident elopes, staff should immediately conduct a head count of each resident, notify management and the resident's power of attorney. When the resident is found, staff should evaluate the resident, initiate neurological checks, and note the circumstances in which the resident was able to exit the building without supervision. NS J reported if these steps were not taken a resident's injuries might not be identified and addressed and the risk for future elopements might not be eliminated.</p> <p>In an interview on 6/13/24 at 11:21am Registered Nurse (RN) E reported in the event of an elopement, a resident should immediately be assessed for injuries, changes in their cognitive status, reasons for the elopement and interventions to reduce the likelihood of future elopements.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/13/24 at 11:42am, Director of Nursing (DON) B reported Registered Nurse (RN) E called her at 6:29pm on 5/15/24 and told her a resident was found outside. DON B reported she spoke with LPN M who confirmed she saw Resident # 100 walking from the front door area of the building as she arrived at the facility. DON B reported she conferred with other members of management, and it was decided that the facility would not consider the event an elopement. When further queried, DON B Resident#103 had an activated durable power of attorney as he was not able to make decisions for himself, and the resident was not safe to go outdoors alone, but she thought the nurse who called the facility had supervised him. DON B confirmed the nurse that called the facility was not actually working at the time and was not with Resident #100 when he exited the building. Upon further questioning, DON B reported Resident #100 was last seen by the staff who worked that afternoon at 5:00pm, and it could not be determined where he'd been from 5:00pm until approximately 6:25pm. DON B confirmed the facility did not complete a head count of other residents, assess Resident #100 for injuries, notify the Medical Director or Resident #100's power of attorney after he was found in the parking lot area.</p> <p>In an interview on 6/13/24 at 12:00pm, Medical Director (MD) V reported he wrote physician orders for residents who were safe to exit the building without supervision. MD V reported he was not comfortable with severely cognitively impaired residents leaving the building alone and would want to know if they did so because he would be concerned for their welfare and would need to assess their medical needs. MD V reported he did not recall being notified of Resident #100 being found outside the building.</p> <p>Review of Resident #100's physician orders revealed no orders to allow him to leave the facility alone.</p> <p>Incident reports for Resident #100 were requested by none were received related to the resident's elopement on 5/15/24.</p> <p>Review of Resident #100's medical records revealed no physician or nursing assessments following his elopement on 5/15/24.</p> <p>Resident #104</p> <p>Review of the facility's Preventative Maintenance Program policy, with a reference date of 1/24, revealed Policy: A preventative maintenance program shall be developed and implemented to ensure the provision of a safe environment for residents. The compliance guidelines within the policy stated: 1. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure equipment (is) maintained in a safe and operable manner. 2. The Maintenance Director shall assess all aspects of the physical plant to determine if Preventative Maintenance (PM) is required. Required PM may be determined from manufacturer's recommendations.</p> <p>Review of a User Manual downloaded from the manufacturer's website, for the (produce name omitted) bariatric electric patient lift, revealed on page 10: Warning .Maintenance MUST be performed periodically and ONLY by qualified personnel. The hooks of the hanger bar and the mounting brackets of the boom should be inspected periodically to determine extent of wear. Regular maintenance of patient lifts .is necessary to assure proper operation. DO NOT overtighten mounting hardware. This will damage mounting brackets.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Admission Record revealed Resident #104, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: intraspinal abscess and granuloma (collection of pus and nodules), muscle weakness and depression.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 5/6/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #104 was cognitively intact.</p> <p>Review of a Care Plan for Resident #104, with a reference date of 2/29/24, revealed a focus/goal/interventions: 1. Focus The resident has an ADL (activities of daily living) self-care performance deficit .Goal: Resident will participate in therapy services .Interventions: TRANSFER: The resident requires mechanical lift with 2 staff assistance for transfers . 2. Focus: The resident has limited physical mobility r/t (related to) lower extremity paralysis .Goal: The resident will remain free of complications related to immobility including .falls .Interventions: PT/OT services.</p> <p>In an interview on 6/13/24 at 8:27am, Resident #104 reported he had recently fallen to floor during a mechanical lift transfer because the lift broke. When further queried, the resident reported he was suspended approximately 3 feet off the ground the sling of the device when the hanger bar holding the sling disconnected from the boom of the device and he fell to the floor on his back. Resident reported he was scared by the event and had a laceration on the back of his head but had no other injuries and did not need to go to the hospital.</p> <p>Review of an incident report for Resident #104, dated 5/18/24 at 1:34pm, revealed Resident #104 fell to the floor while suspended in the sling of the mechanical lift because the 2 pieces of the lift disconnected. The resident refused to go to the hospital for evaluation and was treated for a small head laceration.</p> <p>In an interview on 6/13/24 at 2:16pm, Registered Nurse (RN) R reported she was present on 5/18/24 when Resident#104 fell during a transfer with a mechanical lift. RN R confirmed the fall was the result of the hanger bar falling off the boom of the device. RN R reported it appeared the screw in the mounting bracket that held the 2 pieces together had become loose and slid out causing the 2 pieces to disconnect. RN R reported she immediately removed the device from service and alerted the maintenance department.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Edgewood Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/13/24 at 1:04pm Director of Maintenance (DOM) N reported he did not do routine preventative maintenance on any nursing equipment. DOM N reported it was the responsibility of nursing staff to inform him of any mechanical issues with the equipment and he would then repair devices as needed. When further queried, DOM N reported he recalled preventative maintenance of nursing equipment had been on his calendar of tasks at some point during the [AGE] years he'd worked at the facility, but he had not seen it as an assigned task in quite some time, and none had been done in at least a year. DOM N reported he had not seen the mechanical lift that failed until he was asked to repair it on 5/18/24. DOM N reported he was unsure how often preventative maintenance should be completed on mechanical lifts, but he assumed it should be done at least every six months. DOM N added that the facility had no inventory system for nursing equipment or a system for storing the user's manuals for the devices. DOM N reported without knowledge of the devices the facility had, he could not schedule maintenance. DOM N reported he needed to be able to access the user guides for each device as well. DOM N reported he repaired the mechanical lift that failed but was unsure if the device should have been repaired by the manufacturer. DOM N reported he did not discuss the equipment failure or the repair with the manufacturer.</p> <p>During an observation on 6/13/24 the mechanical lift that was repaired by DOM N sat in Resident #104's room. A sticker on the device indicated the device was originally put into service at the facility on 10/2023.</p> <p>In an interview on 6/13/24 at 1:49pm, Central Supply Clerk (CSC) D reported she did not order the mechanical lift that failed and did not have the owner's manual for the device. CSC D reported the facility did not have a designated individual for ordering equipment. CSC D reported she only stored the user's manuals for the devices she ordered.</p> <p>In an interview on 6/13/24 at 2:22pm, Director of Nursing (DON) B reported preventative maintenance of nursing equipment should be scheduled on the system the maintenance department used to track their daily tasks. DON B reported she could not locate the user's manual for the mechanical lift that failed.</p> <p>In an interview on 6/13/24 at 4:00pm, Nursing Home Administrator (NHA) A reported the facility looked for records of preventative maintenance that had been completed on specific nursing equipment but was not able to locate the information.</p>		