

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 04/03/2025
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 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** 47955</p> <p>Based on observation, interview, and record review the facility failed to develop person centered care plans for 1 (Resident #104) of 9 residents reviewed for person centered care plans resulting in an inaccurate reflection of the resident's current care needs and the potential for unmet care needs.</p> <p>Findings include:</p> <p>Resident #104</p> <p>Review of an Admission Record revealed Resident #104 was male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: psychotic disorder with delusions and dementia with behavioral disturbances.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 1/10/2025 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #104 was severely cognitively impaired, (BIMS score 0-7 indicates severe cognitive impairment).</p> <p>During an observation on 3/31/25 at 8:35 am, Resident #104 was in his wheelchair in the hallway, wearing shorts, and the tubing to a foley catheter was noted along the inner side of his left leg and attached to a drainage bag hanging from his wheelchair.</p> <p>Review of Order Summary for Resident #104 revealed assess foley (urinary catheter) patency twice daily-change with no longer patent 18 fr,(french/ catheter sizing) 5ml (milliliters) balloon every shift with a start date of 3/24/25.</p> <p>Review of Care Plan for Resident #104 revealed Focus/goal/interventions resident is at risk for falls r/t incontinence .resident will not sustain injury .foley for urinary retention initiated 3/26/25 . no care plan focus/goal/interventions noted for enhanced barrier precautions related to a foley catheter.</p> <p>In an interview on 4/2/25 at 8:52 am, Assistant Director of Nursing/Unit Manager/Infection Preventionist (ADON/UM/IP) D reported that enhanced barrier precautions should be implemented for anyone with a foley catheter. ADON/UM/IP D reported that a care plan should be in place for both the catheter and the enhanced barrier precautions.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/3/25 at 9:00 am, Licensed Practical Nurse/Supervisor (LPN/S) DD reported Resident #104 did have a foley catheter in place. LPN/S DD reported that care plans were a team effort, but she was responsible for creating and updating interventions for the clinical items for residents.</p> <p>In an interview on 4/3/25 at 10:02 am, Director of Nursing (DON) B reported her expectations were that a resident with a foley catheter should be in enhanced barrier precautions and a care plan needed to be in place for both the catheter and the enhanced barrier precautions.</p> <p>In an interview on 4/3/25 at 2:01 pm, ADON/UM/IP D reported Resident #104 did have a foley catheter, should be on enhanced barrier precautions. ADON/UM/IP D confirmed that Resident #104 did not have a care plan in place for enhanced barrier precautions.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955</p> <p>Based on observation, interview, and record review the facility failed to revise person centered care plan for 1 (Resident #106) for 9 residents reviewed for person centered care plans resulting in an inaccurate and incomplete description of resident current care needs and the potential for unmet care needs.</p> <p>Findings include:</p> <p>Resident #106</p> <p>Review of an Admission Record revealed Resident #106 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: traumatic subdural hemorrhage with loss of consciousness.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 1/23/2025 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #106 was severely cognitively impaired (BIMS score 0-7 indicates severe cognitive impairment).</p> <p>In an interview on 3/31/25 Nursing Home Administrator (NHA) A reported that Resident #106's diet was recently advanced and Resident #106's feeding tube (G-tube, tube inserted through the skin directly into the stomach to be used to provide hydration and nutrition for someone who cannot eat orally) was no longer being used for supplemental feedings.</p> <p>Review of Order Summary for Resident #106 revealed Diet . Regular diet, mechanical soft texture, Honey thickened Fluids consistency, built up utensils/spoon and Enteral feed order every 4 hours for increased hydrations 100 ml (milliliters) of Water flush for hydration both with a start date 3/25/25.</p> <p>Review of Care Plan for Resident #106 revealed Focus . has nutritional problem or potential for nutritional problem r/t (related to) g-tube .interventions .provide and serve diet as ordered: regular diet, puree texture, nectar thick liquids initiated on 10/28/25 and revised on 2/24/25. Focus .has a swallowing problem r/t coughing or choking during meals or swallowing med .Goal . will not have injury related to aspiration . Intervention .regular diet with pureed texture, nectar thick liquids initiated on 11/5/24 and revised on 3/12/25.</p> <p>During an observation on 4/2/25 at 8:50 am, on the wall outside of Resident #106's room next to his name was a picture of a honey pot and honeycomb.</p> <p>In an interview on 4/2/25 at 8:51 am, Registered Nurse (RN) GG reported the honey pot picture was a visual aide for staff to know that Resident #106 was on honey thick liquids.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/2/25 at 9:18 am, Assistant Director of Nursing/Unit Manager/ Infection Preventionist (ADON/UM/IP) D reported she was now the unit manager on the rehab unit where Resident #106 resided, and she was responsible for updating resident care plans. ADON/UM/IP D reported she had not updated Resident #106's care plan at all.</p> <p>In an interview on 4/3/25 at 9:00 am, Licensed Practical Nurse/Supervisor (LPN/S) DD reported that care plans were a team effort and that the unit managers were responsible for updating clinical items. LPN/S DD reported that the dietary manager should update care plans, but nursing could do it too.</p> <p>In an interview on 4/3/25 at 10:00 Director of Nursing (DON) B reported that diet care plans should be updated by the dietary manager, but there was no active dietary manger in the building. DON B reported the unit managers should update care plans. DON B reported that the unit Resident #106 did not have a unit manager, and that ADON/UM/IP D was covering the role at this time. DON B reviewed Resident #106's diet care plan and confirmed that it was inaccurate. DON B reported that her expectations were that staff followed the care plans and that care plans were accurate.</p> <p>During an observation on 4/3/25 at 10:02 am, DON B was noted to update Resident #106's diet care plan to mechanical soft texture to match his current diet order. When queried, DON B stated I didn't know his liquids were honey thick. DON B then corrected the diet order once again to reflect the correct liquid order.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955</p> <p>This citation pertains to intake MI00148764</p> <p>Based on interview and record review the facility failed to provide activities of daily living (ADL) to dependent residents, specifically showers to 2 (Resident #101 and Resident #102) of 3 residents reviewed for activities of daily living and showers, resulting in showers not being given as scheduled.</p> <p>Findings include:</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: cerebral palsy (a disorder that affects movement and muscle tone) and the need for assistance with personal care.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 3/7/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #105 was cognitively intact (BIMS score 12-15 indicates no cognitive impairment).</p> <p>In an interview on 3/31/25 at 8:32 am, Resident #101 reported she went a week and a half without a shower. Resident #101 reported she should get a shower twice a week and her shower days were Tuesday and Saturday.</p> <p>Review of River bath schedule dated 10/10/24 provided by Licensed Practical Nurse/ Supervisor (LNP/S) DD revealed Resident #101's scheduled shower days were Monday and Thursday on the 2-10 pm shift and the revised version dated 3/5/25 revealed Resident #101's scheduled shower days were Tuesday and Saturday on the 2-10 pm shift.</p> <p>Review of facility provided shower sheets for the month of January for Resident #101 revealed no documented shower between the dates of 1/10/25 and 1/22/25, for a total of 12 days with no documented shower.</p> <p>Review of facility provided shower sheets for Resident #101 for the Month of March 2025 revealed 3/3/25 unable to give shower today due to 2 CNAs on the floor passing dinner trays, feeding resident and putting residents to bed after dinner, UM (Name Omitted) is aware .Next documented shower was 3/9/25, 7 days later. Resident #101 documented shower on 3/22/25 and then the next documented shower was 3/30/25, again 7 days later.</p> <p>Review of Progress Notes for Resident #101 revealed no documented refusals for showers during the month of March.</p> <p>In an interview on 4/2/25 at 9:27 am, Resident #101 reported that she did not receive her shower the day before due to there not being a shower hoyer sling available. Resident #101 reported she was told she would get a shower on her next scheduled shower day.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Shower sheet provided by the facility for Resident #101 revealed 4/1/25 bed bath, no hoyer pads and indicated that the shower was not given.</p> <p>In an interview on 4/1/25 at 2:15 pm, CNA Q reported that showers are the first thing to get missed on a hectic day, or if there was an emergency. CNA Q reported if there was too much going on during the shift the showers were chucked to the side. CNA Q reported that showers are to be documented on the shower sheet, including refusals, and given to the nurse to sign off; there was no other way to documents showers.</p> <p>Resident #102</p> <p>Review of an Admission Record revealed Resident #102 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: multiple sclerosis (a condition that attacks the central nervous system of the body) and the need for assistance with personal care.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 2/19/2025 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #102 was cognitively intact (BIMS score 12-15 indicates no cognitive impairment).</p> <p>In an interview on 3/31/25 at 8:36 am, Resident #102 reported she went about 9 days without a shower. Resident #102 reported she should get a shower twice a week on Wednesday and Sunday.</p> <p>Review of River bath schedule dated 10/10/24 provided by LPN/S DD revealed Resident #102's scheduled shower days were Tuesday and Friday on the 2-10 pm shift and the revised version dated 3/5/25 revealed Resident #102's scheduled shower days were Sunday and Wednesday on the 2-10 pm shift.</p> <p>Review of facility provided shower sheets for Resident #102 for the month of March 2025 revealed no documentation regarding a shower provided between the dates of 3/20/25 and 3/31/25, a total of 12 days of no documented shower.</p> <p>Review of Progress Notes for Resident #102 revealed no documented refusals for showers during the month of March.</p> <p>In an interview on 4/1/25 at 9:50 am, Certified Nurse Assistant (CNA) V reported that the CNAs are responsible for the showers for their assigned group each shift. CNA V reported that sometimes showers do not get done on the shift. CNA V reported that documentation for a shower was done on a shower sheet and provided to the nurse.</p> <p>In an interview on 4/1/25 at 12:40 pm, LPN/S DD reported she had recently changed the shower schedule. LPN/S DD reported that CNAs had to document showers on the shower sheets, there was no other place for them to document. LPN/S DD reported nurses were expected to document refusals in a progress note.</p> <p>In an interview on 4/1/25 at 2:40 pm, Director of Nursing (DON) B reported her expectations were that shower were done on the day and shift scheduled. DON B stated short staffed was not a reason to skip a shower. DON B reports standard of care was two showers a week. DON B reported that the shower sheets completed by the CNAs and signed off by the nurses were the only documentation for completed showers.</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** 47955</p> <p>This citation pertains to intakes MI00150708, MI00150714, and MI00151319.</p> <p>Based on observation, interview and record review the facility failed to ensure adequate supervision for safety for 3 (Resident #104, Resident #105, and Resident #106) of 3 residents reviewed for supervision resulting in Resident #105 hitting Resident #104, Resident #105 spitting on Resident #104 and Resident #106 eloping (exit without supervision) from the building.</p> <p>Findings include:</p> <p>Resident #104</p> <p>Review of an Admission Record revealed Resident #104 was male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: psychotic disorder with delusions and dementia with behavioral disturbances.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 1/10/2025 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #104 was severely cognitively impaired, (BIMS score 0-7 indicates severe cognitive impairment).</p> <p>Resident #105</p> <p>Review of an Admission Record revealed Resident #105 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: unspecified dementia, with other behavioral disturbance.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 12/25/24 revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #105 was moderately cognitively impaired. (BIMS score 8-11 indicates moderate cognitive impairment).</p> <p>In an interview on 4/2/25 at 3:20 pm, Resident #105 stated He (Resident #104) called me a F***** B****. I stopped, walked back to him without my walker, and I spat on him. Resident #105 reported she was upset by the way he treated the staff. Resident #105 reported the altercation between the two residents started long before Resident #104 called her names.</p> <p>Review of incident report provided by the facility dated 2/14/25 at 11:30 am, revealed .Resident #105 and Resident #104 speaking loudly to each other .Resident #104 was heard saying well you're bossy and rude and mean . Resident #105 responded back with okay fat-a**, you want to fight me? I'll fight .Resident #105 was observed walking with her walker to Resident #104 .Resident #105 was heard saying okay fat-a** fight me! Go ahead, do it! . Resident #105 was observed brush (sic) Resident #104's arm with her fingers, and (Name Omitted) the witness then separated them . Resident #105 returned to her spot at the table and remained quiet. Both residents were able to finish the activity at the penny auction without incident . Residents are to remain separated and monitoring to reduce further instances of negative interaction .</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 4/3/25 at 9:00 am, Licensed Practical Nurse/Supervisor (LPN/S) DD reported Resident #105 and Resident #104 did have a couple of altercations. The first one, Resident #104 was in the dining room yelling, and Resident #105 tapped him and told him to cut it out. LPN/S DD reported during the second one Resident #105 spit on Resident #104. LPN/S reported that immediate intervention in both situations was to separate the residents. LPN/S reported Resident #104 and Resident #105 sit at different areas in the dining room. LPN/S reported she was not aware of any other interventions for Resident #104 and Resident #105.</p> <p>Review of incident report provided by the facility dated 2/17/25 at 6:55 pm revealed .Resident #105 reported an altercation with another resident. Resident #105 reported that Resident #104 was making fun of her after dinner while they were still in the dining room. She then left her walker, walked over to him and spat in his face. Per her report. The nurse reported Resident #105 was very upset .Resident #104 was also visibly upset and confused, having difficulty expressing the situation due to cognitive deficient but was visibly agitated the residents are now resting in their respective rooms, apart from each other .The kitchen staff also notified the administrator and will be interviewed</p> <p>In an interview on 4/3/25 at 9:42 am, Certified Nurse Assistant (CNA) I reported she was aware that Resident #104 and Resident #105 had gotten into it before but was unaware of any ongoing interventions regarding Resident #104 and Resident #105.</p> <p>In an interview on 4/3/25 at 9:45 am, Registered Nurse (RN) LL reported Resident #104 and Resident #105 have a personality conflict, but there are no specific interventions that she needed to observe or maintain regarding the two residents.</p> <p>Review of Behavior Log for Resident #104 for February 2025 revealed .2/2 1900-2100 (7pm - 9pm) yelling . 2/13 6:55 am yelling .2/16 3:00 pm yelling, screaming, threatening, residents and CNAs, 2/18 8:00 pm yelling at another resident .2/28 4:44 pm yelling and cussing . interventions included in the log were redirection, talking to resident, told not to yell at other, and all behaviors were noted to be documented as no improvement .</p> <p>Review of Care Plan for Resident #104 revealed focus .has potential to be verbally aggressive with staff . resident will verbalize understanding of need to control behavior .interventions-administer medications . assess resident's understanding of the situations .observe and document behaviors and attempted interventions . With initiation dates of 7/7/2021. Review revealed no noted interventions related to the two recent interactions with Resident #105.</p> <p>Review of Behavior Log for Resident #105 for February 2025 revealed no noted documentation of behaviors. The log was blank.</p> <p>Review of Care Plan for Resident #105 revealed Focus .resident has a behavior problem . Goal . resident will have fewer incidents . Interventions . administer medications as ordered, caregivers to provide opportunity for positive interactions attention .if reasonable, discuss resident's behavior .Intervene as necessary to protect the rights and safety of others .approach/speak in a calm manner, divert attention. Remove from situation and take to alternative location as needed .observe for behavior episodes and attempt to determine underlying cause .all with an initiation date of 8/29/2024 . Focus . history of verbal aggression added on 4/3/2025.</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 4/3/25 at 12:00 pm, Nursing Home Administrator (NHA) 'A reported the facility staff does not complete an incident report following a resident-to-resident altercation.</p> <p>In an interview on 4/3/25 at 1:47 pm, CNA V reported she was not aware of any interventions she needed to maintain for Resident #104 and Resident #105.</p> <p>In an interview on 4/3/25 at 1:55 pm, CNA M reported that there was no behavior concerns with Resident #104 and Resident #105 interacting and there was nothing she needed to do.</p> <p>Review of Progress Notes for Resident #104 and Resident #105 revealed no noted documentation regarding either incident that occurred between them in February 2025.</p> <p>In an interview on 4/3/25 at 2:22 pm, Assistant Director of Nursing (ADON) D reported she was aware that there was an altercation between Resident #104 and Resident #105, but she did not know the details. ADON D reported that immediate interventions should be documented in the incident report and if not there then in a progress note. ADON D reported that she was not aware of any interventions for the two residents.</p> <p>In an interview on 4/3/25 at 2:48 pm, Director of Nursing (DON) B reported Resident #105 spit on Resident #104. DON B reported the immediate intervention was to separate the residents. DON B reported that SSD MM does three follow up days of interviews with each resident, and Resident #105 was referred for medication evaluations. When further queried, DON B reported that there were no other interventions put into place, beside immediate separation, to prevent further interaction between Resident #105 and Resident #104 after the incident occurred on 2/14/25. DON B confirmed that a second incident occurred between Resident #105 and Resident #104 on 2/17/25.</p> <p>In an interview on 4/3/25 at 3:48 pm, SSD MM reported she was responsible for behavior care plans. SSD MM reported she did not update or implement any new interventions for Resident #104 and Resident #105 following either of the incidents that occurred. SSD MM reported that if staff was notified of new interventions, it was by word of mouth only.</p> <p>Resident #106</p> <p>Review of an Admission Record revealed Resident #106 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: traumatic subdural hemorrhage with loss of consciousness.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 1/23/2025 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #106 was severely cognitively impaired (BIMS score 0-7 indicates severe cognitive impairment).</p> <p>During an observation on 3/31/25 at 8:15 am, at the entry door to the facility a framed paper was noted with a 4-digit code indicating the code needed to be inputted into the keypad to gain entry to the building.</p> <p>In an interview on 3/31/25 at 9:30 am, NHA A reported he put the lock on the front door when the Resident #106 got out of the building.</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 Nursing Note for Resident #106 dated 1/8/25 15:43 (3:43 pm) revealed Resident noted to be pushing on facility door and attempting to exit the facility. Resident continues to say home staff attempt to redirect resident with tactile games, conversation, 1:1 attention, and assist resident with ambulation through the facility in his WC (wheelchair) .</p> <p>Review of Elopement/Wander Risk for Resident #106 dated 1/8/25 revealed .score 14 . score key 11 or above high risk .</p> <p>Review of Nursing Note for Resident #106 dated 1/9/25 6:53 am, revealed resident tolerating room move . increased staff supervision provided through the shift .</p> <p>Review of Care Plan for Resident #106 dated 1/10/25 revealed Focus .resident is an elopement risk/wanderer r/t (related to) TBI (traumatic brain injury) and pressing on facility door to exit .Goal . resident's safety will be maintained .Interventions .Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers playing with hanging Velcro ball toss .</p> <p>Review of Nursing Note for Resident #106 dated 3/10/25 at 20:24 pm, (8:24 pm) revealed CNA reported to this nurse that resident was observed walking in the parking lot, encouraged to come back inside and assisted to Broda (high back specialized wheelchair) .Resident taken to Meadow secured unit per DON.</p> <p>In an interview on 3/31/25 at 12:14 pm, RN KK reported Resident #106 was an elopement risk prior to the day he exited the building. RN KK reported Resident #106 was on one-to-one supervision when he eloped from the building, but it was hard to keep the one-to-one staffed. RN KK reported the front door was locked by the office staff when they left for the day. RN KK reported the door was unlocked the day Resident #106 left the building.</p> <p>In an interview on 3/31/25 at 12:35 pm, CNA N reported Resident #106 had been on one-to-one supervision for a while. CNA N reported the front doors to the building were now locked, but that the residents know the code to unlock the door.</p> <p>In an interview on 3/31/25 at 12:14 pm, RN GG reported Resident #106 was not an elopement risk when he first admitted , but as he became more alert, he became a safety risk. RN GG reported at one point he was moved into the secure unit, but it was determined he was not appropriate in there. RN GG reported Resident #106 had been moved all over the building and was now on one-to-one supervision. RN GG reported there isn't always a staff member to cover Resident #106's one to one. RN GG reported she was the nurse on duty the night Resident #106 exited the building, there were three CNAs on the hall with her, and Resident #106 did not have a one-to-one staff member.</p> <p>Review of Post Fall Review for Resident #106 dated 1/31/25 revealed .List the immediate fall interventions(s) put into place: one to one attention. Close ovservation (observation).</p> <p>Review of IDT Fall Review for Resident #106 dated 1/31/25 revealed root cause analysis: poor safety awareness; TBI .Describe new safety intervention (s): 1:1 (one to one) supervision during waking hours.</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 Care Plan for Resident #106 dated 3/13/25 revealed .interventions .Provide 1:1 supervision during waking hours .</p> <p>In a telephone interview on 3/31/25 at 1:09 pm, CNA S reported he was walking past the front entrance on the evening of 3/10/25 and observed Resident #106's Broda wheelchair by the front entrance empty. CNA S reported he knew it was Resident #106's wheelchair, and he went to investigate. CNA S reported when he got closer to the front doors, he could see Resident #106 outside of the building, under the canopy, near the brick pillars in the driveway. CNA S reported he exited the building and assisted Resident #106 back into the building. When queried, CNA S reported he did not put in a code to open the doors, they were unlocked. CNA S reported he was aware that Resident #106 was an elopement risk, and that Resident #106 was on a one-to-one supervision at that time. CNA S reported there was not a one-to-one staff member for Resident #106 that night, and that another CNA was assigned to Resident #106. CNA S reported it was very hard to have an assignment and watch Resident #106 at the same time. CNA S reported Resident #106 would be unobserved when the assigned CNA went into a room to care for another assigned resident.</p> <p>In an interview on 3/31/25 at 2:40 pm, Receptionist (R) FF reported she locked the doors when she left for the day, but now the doors are locked at all times now.</p> <p>In an interview on 3/31/25 at 2:45 pm, Business Office Manager (BOM) E reported she unlocked the door when she arrived to work between 7:15 and 8:00 am, and she would lock the door when she left between 4 and 5:00 pm. BOM E reported the majority of staff can unlock the door with the code. BOM E reported the front door was always locked now after Resident #106's elopement.</p> <p>In an interview on 3/31/25 at 4:25 pm, DON B reported that Resident #106 was placed into the secure unit on 1/8/25 and was moved out of the secure unit on 1/28/25. DON B reported Resident #106 was to be on increased supervision at that time. DON B reported that Resident #106 was identified as an elopement risk on 1/10/25. DON B reported Resident #106 was put on one-to-one supervision after he exited the building on 3/10/25. DON B reported Resident #106 was not on one-to-one supervision prior to his elopement.</p> <p>In an interview on 4/1/25 at 2:25 pm, CNA RR reported she was working and was assigned to Resident #106 the night he eloped from the building. CNA RR reported she was in a room providing care to another resident and CNA S brought Resident #106 back to the unit after he found him outside. CNA RR reported that Resident #106 should have been on one-to-one supervision that night, but there was no staff member to cover the one-to-one.</p> <p>In an interview on 4/1/25 at 3:14 pm, CNA H reported Resident #106 had been a one-to-one supervision for a while. CNA H reported Resident #106 would exit seek and verbalize wanting to go home in the past. CNA H reported there were concerns Resident #106 would get out of the building.</p> <p>Review of timeline provided by DON B related to Resident #106's elopement revealed .10/19/24 Resident #106 not an elopement risk .1/8/25 Resident #106 noted to be pressing on doors and moved to the secure unit; care plan initiated .1/28/25 Resident #106 removed from the secure unit with increased supervision implemented .2/4/25 IDT team met, 1:1 during waking hours with staff .3/10/25 elopement occurred .</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 4/3/25 at 10:02 am, DON B reported that the implemented interventions for prevention of elopement for Resident #106 when he was identified as an elopement risk included increased supervision and the evaluation for a transfer from the facility. DON B reported she did not have Resident #106 on one-to-one supervision until 3/11/25. DON B reviewed the IDT fall review note and confirmed that the intervention of 1:1 supervision during waking hours was not implemented.</p> <p>Review of facility policy Accidents and Supervision with an review date of 05/2024 revealed .Each resident will receive adequate supervision .the process of examining data to identify specific hazards and risks and to develop targeting interventions to deduce the potential for accidents .implementation of interventions using specific interventions to try to reduce the resident's risk from hazards in the environment .communicating the interventions to all relevant staff .assigning responsibility .ensuring the interventions are put into action . supervision is an interventions and a means of mitigating accident risk .based on the individual resident's assessed needs and identified hazards in the resident environment .</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>47955</p> <p>This citation pertains to intake MI00151744</p> <p>Based on observation, interview, and record review the facility failed to ensure the dietary manager had adequate competencies and skill set to carry out the functions of the food and nutrition service resulting in potential for unmet nutrition and hydration needs for all residents who rely on food and hydration from the facility kitchen.</p> <p>Findings include:</p> <p>During an initial tour of the kitchen on 4/2/25 at 9:45 am, Dietary Aide (DA) W and X along with Dietary [NAME] (DC) Y and AA all reported the food delivery that occurred the day before only included milk, eggs, and a few loaves of bread.</p> <p>DA W reported there was food in the pantry, refrigerator, and freezer that could be served to the residents, but it may not be what was on the menu to be served.</p> <p>DC Y was noted to be visibly upset, crying, and reported today's lunch menu was supposed to be ravioli, and that she had to use the ravioli from the emergency food supply. DC Y reported she had used beef stew from the emergency food supply last week and it had not been replaced yet. DC Y reported the menu for breakfast tomorrow included french toast and sausage, but there was not enough bread or sausage to fulfill the menu items for all the residents tomorrow. DC Y also reported she had served ham on Monday because the pot roast that was on the menu was not thawed, and it could not be served. DC Y reported she had to be creative with what she serves for meals, when the items on the menu were not available.</p> <p>DC AA reported the facility was out of juices, specifically the thickened juice (juice that has a thicker consistency for specialized diets related to complications of swallowing when drinking) that was used for therapeutic diets. When queried, DA W and X and DC Y' and AA reported Dietary Manager (DM) BB and Interim Dietary Manager (IDM) Z were responsible for placing orders for food and drinks, and both staff members were PRN (as needed), not full time. All 4 staff members were unsure of when either of them would be in to the building.</p> <p>Neither DM BB nor IDM Z were present during the tour of the kitchen.</p> <p>In an interview on 4/2/25 at 11:40 am, Nursing Home Administrator (NHA) A reported that DM BB had been full time until 3/28/25 and IDM Z had agreed to assist until the position could be filled. NHA A reported DM BB and IDM Z were both considered PRN or as needed employees, neither were full - time. NHA A reported there was a training scheduled for all dietary staff on Thursday, 4/3/25 at 2:30 pm. NHA A reported Registered Dietitian (RD) PP was overseeing the daily functioning of the kitchen.</p> <p>Review of Purchase Order APHN00000769334 provided by the facility and dated 3/31/25 at 4:30 pm and entered by DM BB revealed, .milk 2%- 4 cases, milk whole - 5 cases, milk choc 1% - 2 cases, bread - 1 case, eggs in shell - 1 case, bread white loaf - 1 case, and egg liquid - 1 case .</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a subsequent tour of the kitchen on 4/2/25 at 12:20 pm., DC AA toured the kitchen with this surveyor, and reported the food deliveries should be twice a week, with the larger food order being delivered earlier in the week. The large food order did not arrive yesterday, and there were menu items missing. DC AA reviewed the weekly menu with this surveyor, and the menu revealed sausage and gravy . biscuit . should have been served for breakfast. DC AA stated eggs and toast were served for breakfast today, there was no sausage gravy available, and we had eggs delivered yesterday.</p> <p>In an interview on 4/2/25 at 12:38 pm, IDM Z reported the kitchen did not serve sausage and gravy and biscuits this morning, even though the biscuits were available, IDM Z gestured to a box of biscuits on a cart outside of the manger office in the kitchen. IDM Z stated I have no idea how the ordering is done, that is part of my training tomorrow.</p> <p>A box of biscuits was observed on a cart outside of the manger office in the kitchen, the same box that was indicated by IDM Z as the biscuits that should have been served today, and it was noted to have an expiration date on the biscuits packaging of February 24, 2025.</p> <p>In a telephone interview on 4/2/25 at 1:31pm, RD PP reported she was not overseeing the day-to-day operations of the kitchen but had agreed in a conversation with NHA A, starting today, to be the full-time registered dietitian for the building. RD PP reported being the full-time dietitian was not the same as the dietary manager. RD PP reported she would assist the interim dietary manger to complete the tasks for the day-to-day kitchen management, but she would not be present in the building daily.</p> <p>In a telephone interview on 4/3/25 at 11:45 am, DM BB reported she was no longer working in the facility. She had agreed to assist for 3 weeks, stayed for 5 and was no longer responsible for the day-to-day functions of the kitchen. DM BB reported her last day was Friday, March 28, 2025, and that she had not been in the building this week. When queried, DM BB initially denied placing an order for food for the kitchen this week but then reported that IDM Z had placed the order on Monday, 3/31/25 for milk, eggs, and bread, but had used DM BBs login as IDM Z did not have access to the order system yet. DM BB reported she was in the building for about an hour on Monday to show IDM Z how to place an order for food supplies. DM BB reported she would not be returning to the facility.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>47955</p> <p>This citation pertains to intake MI00151744</p> <p>Based on observation, interview, and record review the facility failed to follow menus resulting in the potential for inadequate nutritional value, unequal substituted nutritional value, and unmet nutritional needs. This deficient practice has the potential to affect all residents who consume food from the facility kitchen.</p> <p>Findings include:</p> <p>During an initial tour of the kitchen on 4/2/25 at 9:45 am, Dietary Aide (DA) W and X along with Dietary [NAME] (DC) Y and AA all reported the food delivery that occurred the day before only included milk, eggs, and bread.</p> <p>DA W reported there was food in the pantry, refrigerator, and freezer that could be served to the residents, but it may not be what was on the menu to be served.</p> <p>DC Y was noted to be visibly upset, crying, and reported there was no sausage and gravy nor biscuits to be served this morning for breakfast. DC Y reported the menu for breakfast tomorrow included French toast and bacon, but there was not enough bread or bacon to fulfill the menu items for all the residents. DC Y reported she had served ham on Monday because the pot roast on the menu was not thawed, and it could not be served. DC Y reported she would have to serve pot roast on Thursday in place of the ham on the menu. DC Y reported she had to be creative with what she served for meals, when the items on the menu are not available. DC Y reported she was able to serve food to the residents, but it was not what was on the menu.</p> <p>When queried, DA W and X and DC Y and AA reported Dietary Manager (DM) BB and Interim Dietary Manager (IDM) Z were responsible for making the substitutions for meals if the menu could not be followed. Both DM BB and IDM Z were PRN (as needed) staff, not full time, and all 4 staff members present were unsure of when either of them would be in to the building today. DC Y stated I have to serve something.</p> <p>Neither DM BB nor IDM Z were present during the tour of the kitchen.</p> <p>Review of Week 1 Menu provided by the facility for the dates of 3/30/25 to 4/5/25 revealed .Monday lunch pot roast w/gravy, winter squash, biscuit .Wednesday breakfast sausage & gravy, cereal of choice, biscuit . Wednesday dinner deli sandwich .Thursday breakfast french toast .Thursday lunch ham baked, broccoli steamed .</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 4/2/25 at 12:20 pm, DC AA reported scrambled eggs were served this morning in place of the sausage gravy, and toast was served in place of the biscuits. DC AA reported there was only 6 loaves of bread, and the menu revealed a deli sandwich for tonight's dinner and French toast for breakfast tomorrow. When queried, DC AA reported 6 loaves of bread was not enough bread, and they would have to substitute pancakes for the French toast tomorrow. DC AA reported she had never seen a substitution log, but believed the manager had to approve a menu substitution.</p> <p>In an interview on 4/2/25 at 12:38 am, IDM Z reported the manager was responsible for notifying the registered dietitian about any need for substitutions, and the dietitian would need to approve the substitutions. When queried, IDM Z stated I have nothing to do with the menus.</p> <p>In a telephone interview on 4/2/25 at 1:31 pm, Registered Dietitian (RD) PP reported she had not been to the building at all during the month of March 2025. RD PP reported she does not sign off on menus, the dietary manager was responsible for that. RD PP reported she did need to be notified of any substitutions the dietary manager approved as she would need to sign off on the facility's substitution log. When queried, RD PP stated she had not been notified of any substitutions in the last month, and specifically she had not approved any substitutions for Monday 3/31/25 or Wednesday 4/2/25.</p> <p>In an electronic communication (E-mail) on 4/2/25 at 2:08 pm, Nursing Home Administrator (NHA) A reported the cans of sausage gravy were dented when they arrived, and the kitchen was unable to use them this morning for breakfast. They had to substituted.</p> <p>In a telephone interview on 4/2/25 at 2:10 pm, RD PP reported the dented cans of sausage gravy that could not be used, should have resulted in her being notified by the dietary manager that a substitution was needed, and the substitution should have been logged into the substitution log for her to sign off on approval of the nutritional exchange. RD PP reported she was not aware of the substitution.</p> <p>In an interview on 4/3/25 at 8:45 am, DC Y reported there was no substitution log that was used when they needed to exchange a menu item.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955</p> <p>Based on observation, interview, and record review the facility failed to ensure the use of personal protective equipment (PPE) for residents in enhanced barrier precautions (EBP) for 2 (Resident #104 and Resident #106) of 4 residents reviewed for enhanced barrier precautions personal protective equipment use, resulting in the potential for introduction of infection, disease transmission, and cross contamination.</p> <p>Findings include:</p> <p>Resident #104</p> <p>Review of an Admission Record revealed Resident #104 was male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: psychotic disorder with delusions and dementia with behavioral disturbances and need for assistance with personal care.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 1/10/2025 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #104 was severely cognitively impaired, (BIMS score 0-7 indicates severe cognitive impairment).</p> <p>During an observation on 3/31/25 at 8:35 am, Resident #104 was in his wheelchair in the hallway, wearing shorts, and the tubing to a foley catheter was noted along the inner side of his left leg and attached to a drainage bag hanging from his wheelchair.</p> <p>Review of Order Summary for Resident #104 revealed assess foley (urinary catheter) patency twice daily-change with no longer patent 18 fr,(french/ catheter sizing) 5ml (milliliters) balloon every shift with a start date of 3/24/25.</p> <p>Review of Care Plan for Resident #104 revealed no care plan focus/goal/interventions noted for enhanced barrier precautions.</p> <p>In an interview on 4/2/25 at 8:52 am, Assistant Director of Nursing/Unit Manager/Infection Preventionist (ADON/UM/IP) D reported that enhanced barrier precautions should be implemented for anyone with a foley catheter. ADON/UM/IP D reported EBP included the wearing of gown and gloves during cares by staff members.</p> <p>In an interview on 4/3/25 at 9:00 am, Licensed Practical Nurse/Supervisor (LPN/S) DD reported Resident #104 did have a foley catheter in place and should be in enhanced barrier precautions.</p> <p>In an interview on 4/3/25 at 10:02 am, Director of Nursing (DON) B reported her expectations were that a resident with a foley catheter should be in enhanced barrier precautions, and staff should utilize PPE during cares.</p> <p>During an observation on 4/3/25 at 1:45 pm, LPN/S DD and Certified Nursing Assistant (CNA) SS were observed entering Resident #104's room to assist him out of bed. Neither staff member donned (put on) any PPE prior to assisting Resident #104 to transfer to his wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #106</p> <p>Review of an Admission Record revealed Resident #106 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: traumatic subdural hemorrhage with loss of consciousness and gastrostomy status (G-tube/feeding tube).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 1/23/2025 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #106 was severely cognitively impaired (BIMS score 0-7 indicates severe cognitive impairment).</p> <p>During an observation on 3/31/25 at 12:35 pm, signage was noted outside of Resident #106's room indicating that he was in enhanced barrier precautions and that personal protective equipment, gown and gloves were needed for high contact care areas.</p> <p>Review of Order Summary for Resident #106 revealed .Enhanced barrier precautions: providers and staff must wear gown and gloves or the following high-contact resident care activities .dressing, bathing, transferring, changing linens, providing hygiene .every shift for PEG (G-tube) . with a start date of 10/31/24.</p> <p>Review of Care Plan for Resident #106 with a start date of 1/2/25 revealed Focus .requires enhanced barrier precautions .Interventions .wear PPE (gown and gloves) during high contact resident care activities .</p> <p>During an observation on 4/1/25 at 2:25 pm, CNA G was observed sitting on Resident #106's bed, leaning over his body and adjusting his pillows, blankets, and other linens. CNA G was not wearing any PPE.</p> <p>In an interview on 4/2/25 at 8:50 am, Registered Nurse (RN) GG reported that Resident #106 was on enhanced barrier precautions related to his G tube (a tube inserted through the skin directly into the stomach to provide nutrition and hydration). RN GG stated there is no way the CNAs could do that, he is impulsive. RN GG reported the CNAs do not wear any PPE at all when caring for him.</p> <p>In an interview on 4/2/25 at 8:52 am, ADON/UM/IP D reported staff only has to use PPE in enhanced barrier precautions when they are working with the specified area of concern. Resident #106 has G tube and is in enhanced barrier precautions but there is no way anyone was going to follow that with him. ADON/UM/IP D reported she educated staff, we post signs outside of the rooms, and they are noncompliant with wearing PPE in the resident's room who are in EBP.</p> <p>During an observation on 4/2/25 at 12:36 pm, CNA M was in Resident #106's room and assisting him into the bathroom. CNA M was not wearing any PPE.</p> <p>During an interview on 4/2/25 at 3:15 pm, CNA G reported that Resident #106 was not in EBP.</p> <p>During an interview on 4/2/25 at 3:16 pm, CNA RR reported that EBP was used when a resident has a significant wound. CNA RR reported if the wound was small, she didn't need to wear PPE to assist the resident with care. CNA RR reported that Resident #106 was not on EBP, and that the signage posted outside of Resident #106's room was indicated for his former roommate.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy Enhanced Barrier Precautions with an implemented date of 5/20/2024 revealed .all staff receive training on high-risk activities .an order for enhanced barrier precautions will be obtained for residents with any of the following: .indwelling medical device .urinary catheter, feeding tubes .PPE for enhanced barrier precautions is only necessary when providing high-contact care activities .the infection preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.</p> <p>In an interview on 4/2/25 at 9:18 am, ADON/UM/IP D reported that the unit managers in addition to herself were to monitor the staff for PPE use related to enhanced barrier precautions. on the units.</p> <p>Review of Centers for Disease Control and Prevention (CDC) dated March 20, 2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or 2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Effective Date: April 1, 2024 .</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 04/03/2025
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 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>47955</p> <p>Based on interview and record review, the facility failed to ensure that a qualified Infection Preventionist worked at least part-time at the facility, was provided sufficient time to perform the Infection Preventionist role, and was present to properly assess, implement, and manage the Infection Prevention and Control Program.</p> <p>Findings include:</p> <p>During an interview on 4/2/25 at 8:52 am, Assistant Director of Nursing/Unit Manager/ Infection Preventionist (ADON/UM/IP) D reported she educates on enhanced barrier precautions, (EBP) but staff was not compliant with wearing personal protective equipment (PPE). ADON/UM/IP D reported she does perform audits on residents who are in EBP, but the audit was for gown and glove supply availability, not use by staff. ADON/UM/IP D reported she was now the unit manager on the rehab unit in addition to being the ADON and IP. ADON/UM/IP D reported she was also pulled to work the floor and cover open shift or parts of shift weekly. ADON/UM/IP D reported she was on call one weekend a month and was usually called into the building to work during her on call time. ADON/UM/IP D reported that last week she was finally able to upload all the resident immunization information from last fall into the state database.</p> <p>Review of Facility Assessment with an approved date of 7/11/2024 revealed Nursing services .Assistant director of nursing, an RN with 2+ years of experience and management skills, Registered nurse with administrative duties, RN with 2+ years of experience and management skills, Licensed practical nurses with administrative duties, LPN with 2+ years of experience and management skills, Infection Preventionist, Duties performed by Assistant Director of Nursing . The infection preventionist role was an additional role to the assistant director of nursing. The assistant director of nursing role and the registered nurse with administrative duties (AKA - Unit Manager) were two separate positions designed for two employees.</p> <p>Review of Assistant Director of Nursing Job description with a date of 2023 revealed .position purpose assists the director of nursing in planning, organizing, developing, and directing the overall operations of the nursing services department in accordance with local, state, and federal standards and regulations, established facility policies, and procedures and as my be directed by the administrator and medical director to provide appropriate care .</p> <p>Review of Infection Preventionist job description with a date of 2023 revealed .position purpose, develops, implements, and maintains a facility-wide infection preventions and control program .</p> <p>Review of Nursing Unit Manager job description with a date of 2023 revealed .assists the Director of Nursing; plans, develops, organizes, and coordinates the day-to-day functions of the unit .</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 04/03/2025
NAME OF PROVIDER OR SUPPLIER Edgewood Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 55378 Wilbur Rd Three Rivers, MI 49093	
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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of facility policy Enhanced Barrier Precautions with an implemented date of 5/20/2024 revealed .all staff receive training on high-risk activities .indwelling medical device .urinary catheter, feeding tubes .PPE for enhanced barrier precautions is only necessary when providing high-contact care activities .the infection preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.</p> <p>In an interview on 4/3/25 at 2:01 pm, ADON/UM/IP D reported she has several responsibilities on the units with her role of ADON and IP. The additional responsibilities for UM now add tasks such as completing admissions and discharges of residents, acquiring medical equipment if needed for a resident at discharge and managing the day-to-day operations of the rehab unit. ADON/UM/IP reported the last time she had completed any infection control education to staff was in December. ADON/UM/IP reported she had not had time to reeducate staff on the use of PPE for residents on EBP, and she was aware that PPE was frequently not being used for resident's in EBP. ADON/UM/IP D reported now that the role of unit manager had been added to her responsibilities, she had spent about 3 hours a week completing infection control tasks and responsibilities. ADON/UM/IP reported she should be spending 20 to 25 hours a week on infection control.</p> <p>In an interview on 4/3/25 at 2:48 pm, Director of Nursing (DON) B reported the ADON/UM/IP D was recently assigned the additional role of UM when the former UM resigned a few weeks ago. DON B stated, she (ADON/UM/IP D) wears 5 hats and doesn't have time to time to do it all.</p>		