

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2025
NAME OF PROVIDER OR SUPPLIER  The Laurels of Kent		STREET ADDRESS, CITY, STATE, ZIP CODE  350 N Center St Lowell, MI 49331	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake 1326155. Based on observation, interview, and record review the facility failed to have sufficient staffing to ensure resident care needs were responded to timely for 5 (Residents #1, 2, 6, 7, and 8) of 7 residents reviewed for sufficient staffing, and the potential to affect all those living at the facility of the facility census of 97 resulting in feelings of anger, frustration, and/or embarrassment. Findings include: Resident #1: During an interview on 8/26/25 at 11:51 AM, Resident #1 reported she had feelings of frustration when she had to wait prolonged times to receive staff assistance getting from her bed to her power chair. Resident #1 reported call light times are often not good (long and reported an example of waiting approximately one and a half hours. Resident #1 reported call light wait times are longest when she wanted to get up out of bed and into her power chair around lunch time. During observations and interviews starting on 8/27/25 at 9:18 AM, the call light monitor behind the nurses' station at the end of the 200s hall and call lights above the door in view of all in the hall were watched. At 9:18 AM, the call light monitor at the nurses' station was lit up (activated/turned on) for Resident #1's room and room [ROOM NUMBER] and the call lights above Resident #1's room and room [ROOM NUMBER] were lit up (activated/turned on). room [ROOM NUMBER]'s call light was turned off/responded to at 9:18 AM, and Resident #1's call light remained on (resident awaiting staff response to a care need). The surveyor then proceeded down to Resident #1's room. Resident #1 was lying on her back in her bed, the call light remained on, and she reported she had put on her call light at 9 AM and was waiting for staff to get her out of bed and into her power chair. Resident #1 confirmed she is unable to transfer independently from bed to chair without staff's assistance but wanted to get up so she could take herself down to the beautician to get her hair colored. Resident #1 reported she was concerned because the beautician only comes one day a week every other week and needed the service while the beautician was available. Resident #1 reported it was after breakfast and in-between meals, so she didn't know what was taking so long. Resident #1 appeared visibly frustrated. Resident #1 reported she felt the staffing levels were low and waited longer than 15 minutes for her call light to be answered four times each week on average. The surveyor waited with the resident until the call light was answered. At 9:41 AM, Beautician K entered Resident #1's room to get the resident for hair care. Beautician K reported that she was with Resident #1 when the call light was put on at 9 AM, or no later than 9:05 AM, so that she could get to the Beautician's room. No other person came into Resident #1's room or addressed Resident #1 until 9:44 AM when Certified Nurse Aide J entered Resident #1's room. CNA J and M got Resident #1 up into her power chair, and Resident #1 began to independently use her power chair to exit her room and start heading down the hall to the Beautician's room at 10:03 AM. During an interview on 8/27/25 at 9:44 AM, Certified Nurse Aide (CNA) J reported the CNA's working the 200 hall was herself (CNA J), CNA L, and CNA M was split working both the 100 and 200 halls. CNA J reported the expectation was 5 minutes to answer a call light. CNA J confirmed there was no significant event that would have created a delay to answer Resident #1's call light and they had been providing routine/normal daily cares for residents. CNA J reported she felt they had enough staff to meet care needs on the day shift this day but reported often when working a later shift there was often no CNA working on the 500 hall and that it was frustrating. (The 500 hall was separated from the 100/200 halls requiring staff to walk down a hallway to access the 500 hall rooms.) CNA J reported she felt 2nds and thirds (evenings and nights) shifts struggle with staffing levels and meeting resident care needs/call lights. During an interview on 8/27/25 at 9:58 AM, Certified Nurse Aide (CNA) F was asked what the facility's call light response time was expected to be. CNA F reported realistically 5-7 minutes. CNA F reported second shift staffing levels suffer/not always having enough staff. During an interview on 8/27/25 at 10:03 AM, Certified Nurse Aide (CNA) M stated, Not on a regular basis when she was asked if the facility is staffed enough to allow time to meet resident needs timely. CNA M confirmed she was working rooms on both the 200s hall and the 100s hall, she hadn't seen Resident #1's call light on as she had been on the 100s hall at the time, and nothing happened this morning out of the ordinary that would have prevented staff from meeting call lights (resident care needs) timely. CNA M reported she felt they were adequately staffed today for the day shift. During an observation and interview on 8/27/25 at 10:44 AM, Resident #1's hair care was completed by the beautician, she was seated upright in her wheelchair in her room, and reported when she had to wait that long, like she did that morning 9 AM-9:44 AM for her call light to be answered, she stated she doesn't yell but I get frustrated and angry. If it had not to 1 hour I may have</p>		