STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235253	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Kent	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. This citation pertains to intake #2713932.Based on interview and record review, the facility failed to ensure residents were free from significant medication errors in 1 (Resident #29) of 3 residents reviewed for pain management services, resulting in Resident #29 missing a dose of scheduled pain medication and experienced pain, frustration and difficulty sleeping. Findings include:Resident #29Review of an admission Record revealed Resident #29 had pertinent diagnoses which included: pain in the right knee and chronic pain.Review of a Minimum Data Set (MDS) assessment for Resident #29, with a reference date of 1/20/2026 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #29 was cognitively intact. Review of section J: Health Conditions Pain Management for Resident #29 revealed a scheduled pain medication regimen, no PRN (as needed) pain medication use, with occasional pain occurring, and the worst being scored a 6 of 10 (10 being the worst pain ever experienced) in the previous 5 days of the assessment.Review of Physician Orders for Resident #29 revealed Oxycodone HCl (hydrochloride) (potent medication used to treat pain) Oral Tablet 10 mg (milligrams) give 10 mg by mouth at bedtime for chronic pain was originally started on 1/31/2025 at the time of admission and had been a continuous order throughout her stay in the facility for pain management, with the most recent renewal of the order on 2/5/26.In an interview on 2/22/26 at 12:07 PM, Resident #29 reported she had severe chronic pain in her back, and it was managed with 10 mg oxycodone at night. Resident #29 reported the pain would be very bad if she didn't have her pain medication as it was scheduled. Resident #29 reported she took one pain pill a day at bedtime.In an interview on 2/22/26 at 2:39 PM, Resident #29 reported there was a situation with her pain medication in January 2026. Resident #29 reported they did not have her medication in the building, the pharmacy would not send it, and the nursing staff was retrieving her pain medication from the backup supply box. Resident #29 reported there was one night, she did not get her pain medication at all and the pain that night escalated to a 10, was unbearable and she did not get much sleep because of it. Review of the Medication Administration Record (MAR) for January 2026 for Resident #29 revealed 10 mg oxycodone was documented held/see nurse's note by Licensed Practical Nurse (LPN) O on 1/8/26.Review of eMar-Medication Administration Note (electronic medication administration record) dated 1/8/26 at 23:47 (11:47 PM), authored by LPN O for Resident #29 revealed . needs new script (prescription). Physician aware.In an interview on 2/24/26 at 1:30 PM, Registered Nurse/ Nurse Manager (RN/NM) R reported Resident #29 told her about her problems with the pharmacy providing her pain medication to the facility, the difficulties the staff had getting the medication out of the backup box, and that she had missed a dose of her oxycodone 10 mg. Review of Controlled Drug Receipt/Record/Disposition Form for Resident #29 dated received 12/23/25 indicated Oxycodone IR (immediate release) Tab 10 mg, included 14 tablets and the last recorded tablet was given to Resident #29 on 1/6/26 and there were no more tablets available.Review of Transactions by Patient ID (Identification) for the backup medication box at the facility for Resident #29 revealed oxycodone IR 10 mg was pulled from back up for Resident #29 on 1/7/26, twice on (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

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 02/24/2026
NAME OF PROVIDER OR SUPPLIER The Laurels of Kent		STREET ADDRESS, CITY, STATE, ZIP CODE 350 N Center St Lowell, MI 49331	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/9/26, 1/10/26, and 1/12/26. No tablet was pulled for Resident #29 on 1/8/26 or 1/11/26.Review of the MAR (Medication administration record) for Resident #29 revealed documentation on 1/11/26 by LPN V that indicated resident #29 received her ordered oxycodone 10 mg tablet at bedtime.In a telephone interview on 2/24/26 at 2:05 PM, LPN O reported she recalled when Resident #29's oxycodone ran out and she had to call the on-call provider to get a new script. She did not recall the exact date but remembered she had gotten a 3-day supply called into pharmacy. LPN O reported that Resident #29 could not go without her pain medication, her pain was too intense if she missed a dose. When queried, LPN O reported she probably documented the mediation was on hold on 1/8/26 because it was not available and then when she was able to pull it out of backup, she just gave it to her. LPN O reported she should have struck out the documentation that the medication was on hold and documented a late entry that it was given, but it was late. LPN O reported she did not document that she had given Resident #29 her pain medication, 10 mg oxycodone, on 1/8/26, but she knew she gave it to her late after she pulled it out of the backup box.Review of Packing Slip revealed on 1/13/26, (Name Redacted) pharmacy delivered 15 tablets of Oxycodone 10 mg for Resident #29.In an interview on 2/24/26 at 10:53 AM Director of Nursing (DON) B reported she didn't know what happened and confirmed that Resident #29 was given the last tablet of her oxycodone 10 mg supply on 1/6/26, back-up supply was used for doses on 1/7/26, 1/9/26, 1/10/26, and 1/12/26 and received her next supply on 1/14/26. DON B reported one dose pulled on 1/9/26 was most likely the late administered dose that was not documented by LPN O. DON B was unable to determine where the documented dose of 10 mg oxycodone that was administered on 1/11/26 for Resident #29 came from. DON B stated It appears Resident #29 did not get a dose that night even though it was documented she did.Multiple attempts to contact LPN V were unsuccessful, and no interview was conducted by the time of survey exit.