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	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Kent (the)	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36221 Based on interview, and record review, the facility failed to timely report an injury of unknown origin to the State Agency in 1 of 1 resident (Resident #94) reviewed for abuse, resulting in the potential for a delayed/incomplete investigation. Findings include: In an interview on 12/18/24 at 4:43 PM, Family Member L reported a concern involving a bruise on Resident #94's right inner thigh. Family Member L reported they noticed the bruise during a visit while Resident #94 was in the bathroom. Family Member L described the bruise as .huge . and reported when they asked the nurse what happened the facility had no explanation. Family Member L reported they were concerned that the large bruise to Resident #94's right inner thigh was not reported or investigated. Review of an Admission Record revealed Resident #94 was a female, with pertinent diagnoses which included severe dementia with agitation, depression, anxiety, high blood pressure, heart disease, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #94, with a reference date of 9/24/24, revealed a Brief Interview for Mental Status (BIMS) score of 8, out of a total possible score of 15, which indicated moderate cognitive impairment. Review of a Progress Note for Resident #94, dated 10/28/24 at 9:26 PM, revealed .Resident is very agitated and swearing. She agreed to speak to (Family Member L). This nurse also spoke to (Family Member L). (Family Member L) reports that (they were) here yesterday and noted a large bruise to (Resident #94's) inner right thigh near the groin. (Family Member L) reports that (they) told the nurse on duty and was wondering what had been done about it . Review of a Progress Note for Resident #94, dated 10/28/24 at 10:12 PM, revealed .With the assistance of a (Certified Nursing Assistant) I observed the bruise to the right inner thigh. It is purple/red in color and about the size of a soft ball. It is mid way between the knee and the groin. Resident has no idea when or how it occurred . (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note for Resident #94, dated 10/29/24 at 9:27 AM, revealed .Guest did have a fall and was on the floor recently looking for her remote to her bed. The remote issue was resolved. The bruise to her right inner thigh very well could be resulted from the fall . No other notes or assessments noted related to the bruise on Resident #94's right inner thigh. In an interview on 12/20/24 at 9:09 AM, Administrator A reported the bruise noted to Resident #94's right inner thigh on 10/28/24 was not reported to the State Survey Agency. In an interview on 12/20/24 at 9:37 AM, Director of Nursing (DON) B reported she met with Family Member L about the bruise noted to Resident #94's right inner thigh on 10/28/24. DON B reported Resident #94 had a fall a few days prior, and stated .we thought the bruise was from that . DON B stated .(Resident #94) self-transfers, she puts herself on the floor .That is what we believed the bruise was from . Review of an Incident/Accident report for Resident #94, dated 10/23/24 at 3:00 PM, revealed .Resident noted to be sitting cross legged on the floor in front of her bed after sliding to the floor. She did not hit her head . Per the report, no injuries were observed at the time of the incident. Note this incident occurred five days prior to identifying the bruise on Resident #94's right inner thigh. No other Incident/Accident reports noted between 10/23/24 and 10/28/24, the date the bruise was identified on Resident #94's right inner thigh. Review of a Total Body Skin Assessment for Resident #94, dated 10/25/24 at 10:32 AM, revealed no new skin issues. In an interview on 12/20/24 at 2:26 PM, Registered Nurse (RN) G reported for any new injury/bruise with unknown origin, an incident report should be completed. RN G reported management would be responsible for the investigation. Review of all Incident/Accident Reports for Resident #94 revealed no Incident/Accident Report or investigation related to the bruise noted on her right inner thigh on 10/28/24.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 36221 Based on interview, and record review, the facility failed to thoroughly investigate an injury of unknown origin in 1 of 1 resident (Resident #94) reviewed for abuse, resulting in an incomplete facility investigation. Findings include: In an interview on 12/18/24 at 4:43 PM, Family Member L reported a concern involving a bruise on Resident #94's right inner thigh. Family Member L reported they noticed the bruise during a visit while Resident #94 was in the bathroom. Family Member L described the bruise as .huge . and reported when they asked the nurse what happened the facility had no explanation. Family Member L reported they were concerned that the large bruise to Resident #94's right inner thigh was not reported or investigated. Review of an Admission Record revealed Resident #94 was a female, with pertinent diagnoses which included severe dementia with agitation, depression, anxiety, high blood pressure, heart disease, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #94, with a reference date of 9/24/24, revealed a Brief Interview for Mental Status (BIMS) score of 8, out of a total possible score of 15, which indicated moderate cognitive impairment. Review of a Progress Note for Resident #94, dated 10/28/24 at 9:26 PM, revealed .Resident is very agitated and swearing. She agreed to speak to (Family Member L). This nurse also spoke to (Family Member L). (Family Member L) reports that (they were) here yesterday and noted a large bruise to (Resident #94's) inner right thigh near the groin. (Family Member L) reports that (they) told the nurse on duty and was wondering what had been done about it . Review of a Progress Note for Resident #94, dated 10/28/24 at 10:12 PM, revealed .With the assistance of a (Certified Nursing Assistant) I observed the bruise to the right inner thigh. It is purple/red in color and about the size of a soft ball. It is mid way between the knee and the groin. Resident has no idea when or how it occurred . Review of a Progress Note for Resident #94, dated 10/29/24 at 9:27 AM, revealed .Guest did have a fall and was on the floor recently looking for her remote to her bed. The remote issue was resolved. The bruise to her right inner thigh very well could be resulted from the fall . No other notes or assessments noted related to the bruise on Resident #94's right inner thigh. In an interview on 12/20/24 at 9:37 AM, Director of Nursing (DON) B reported she met with Family Member L about the bruise noted to Resident #94's right inner thigh on 10/28/24. DON B reported Resident #94 had a fall a few days prior, and stated .we thought the bruise was from that . DON B stated .(Resident #94) self-transfers, she puts herself on the floor .That is what we believed the bruise was from . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Incident/Accident report for Resident #94, dated 10/23/24 at 3:00 PM, revealed .Resident noted to be sitting cross legged on the floor in front of her bed after sliding to the floor. She did not hit her head . Per the report, no injuries were observed at the time of the incident. Note this incident occurred five days prior to identifying the bruise on Resident #94's right inner thigh. No other Incident/Accident reports noted between 10/23/24 and 10/28/24, the date the bruise was identified on Resident #94's right inner thigh. Review of a Total Body Skin Assessment for Resident #94, dated 10/25/24 at 10:32 AM, revealed no new skin issues. In an interview on 12/20/24 at 2:26 PM, Registered Nurse (RN) G reported for any new injury/bruise with unknown origin, an incident report should be completed. RN G reported management would be responsible for the investigation. Review of all Incident/Accident Reports for Resident #94 revealed no Incident/Accident Report or investigation related to the bruise noted on her right inner thigh on 10/28/24.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41027 Based on observation, interview, and record review, the facility failed to post required nurse staffing information on a daily basis, for all 98 residents in the facility, resulting in a lack of available staffing information for residents and visitors. Findings include: In an observation and review of the posting Report of Nursing Staff Directly Responsible for Patient Care document, in the main entryway of the facility on 12/18/24 and 12/19/24, revealed no information recorded in the total hours columns of the document. In an interview on 12/19/24 at 09:53 AM, Medical Records/Scheduler (MRS) JJ reported that she was responsible for posting the daily staffing report. MRS JJ reported that she only recorded the number of staff, and did not know to include how many hours they were working on that day. In an interview on 12/20/24 at 12:31 PM, Nursing Home Administrator (NHA) A reported that she did not know to the nursing hours needed to be reflected on the posting.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41027 Based on observation, interview and record review, the facility failed to maintain complete and accurate medical records for 2 (Resident #14 and #94) of 20 residents reviewed for medical records, resulting in an inaccurate reflection of personal hygiene acceptance, lack of nursing assessment documentation, and the potential for facility staff and providers not having all of the pertinent information to care for residents. Findings include: Resident #14 During an observation on 12/18/24 at 10:02 AM Resident #14 was lying in bed, his nails were very long, his facial hair was overgrown and the hair on his head was greasy and disheveled (messy). During an observation on 12/19/24 at 09:29 AM Resident #14 was lying in bed, his nails were long and dirty, and his facial hair had food substance in it. In an interview on 12/19/24 at 02:08 PM, Certified Nursing Assistant (CNA) I reported that Resident #14 refused grooming of his hair and nails, and did not like to be touched. CNA I reported that Resident #14 verbalized no when staff offer to assist with hair and nails. In an interview on 12/20/24 at 09:16 AM, Social Worker (SW) Y reported that she checked the medical record dashboard to know if residents are refusing care. SW Y had not been told that Resident #14 was refusing care, and he had not refusals on on the dashboard. SW Y reported that when residents refuse care, she would try to encourage a different time, evaluate if there was a reason for the refusals, and/or contact family. Review of Resident #14's Personal Hygiene task record indicated no refusals of care from the past 30 days, and every day indicated that the task had been completed by staff. This documentation was inconsistent with the interview from CNA I. Review of Resident #14's ADL (activities of daily living) Care statement task record indicated yes to the past 30 days of the following statement, Have you provided routine standard care which includes evaluating skin daily and reporting changes, shaving and nail care as needed, turning and repositioning, oral care, washing face and hands, hair care, clean clothes and linens . There were no days marked as resident refused. Resident #94 In an interview on 12/18/24 at 04:43 PM, Family Member (FM) L reported that Resident #94 was supposed to see a dentist for a broken tooth, but she had not heard anything about it. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #94's Nurses Notes dated 11/27/2024 revealed, Resident's daughter (name excluded) in and informed this writer that resident has a broken tooth on the bottom right that was not broken last Thursday when she was here. DON (Director of Nursing) B informed. In an interview on 12/20/24 at 09:31 AM, Nursing Home Administrator (NHA) A reported that the dentist is scheduled to come in next week, but that Resident #94 was not on the list. NHA A was not informed by DON B that the resident needed to see the dentist. In an interview on 12/20/24 at 09:42 AM, DON B reported that she spoke with Resident #94's family about her broken tooth, and talked to staff about it also. DON B reported that she assessed Resident #94's tooth and the resident did not have any issues with pain or eating. DON B reported that she did not refer the resident to the dentist and did not document her findings.