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

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the dish machine in a state of repair that would allow for the machine's operational requirements to be met.Findings Include:On 2/22/26 at 10:00 AM, observation of the kitchen dish machine found that it was not reaching proper temperature or pressure for the wash and rinse cycles. A review of the machines' data plate (that shows the minimum requirements) found that the Wash temperature should be 150F - 160F, Rinse temperature should be 180F from the manifold (for a contact of 160F), and the final rinse pressure should be 20 pounds per square inch (psi). At this time, five cycles of the dish machine were run with the following characteristics observed: The wash cycle gauge showed between 140F-146F, the rinse pressure gauge showed between 35-50 psi, and the dish plate thermometer, which tracks the contact temperatures, showed contact temperatures of 137F-150F. A record review of the document entitled Dishmachine Temperature / Sanitizer Log, dated [DATE], found that the morning rinse temperature was recorded low on the log with no corrective action noted. Further review of the log found eight recorded hot water sanitizing rinse temperatures below the required 180F from the manifold. On 2/22/26 at 11:15 AM, a follow up tour of the kitchen found that the dish machine was still not reaching the minimum manufactures requirements. Certified Dietary Manager (CDM) QQ ran a thermo-tape test strip through, and it did not trigger the 160F contact temperature required. CDM QQ stated they would have to use the three-compartment sink and get someone to come check on the unit.

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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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review the facility failed to consistently honor food preferences for 5 (Residents #106, 91, 31, 5, and 42) of 11 residents reviewed for dining resulting in being served disliked foods, frustration, decreased meal enjoyment, and the potential for unintended weight loss due to decreased oral intake.Findings include:Resident #106: Review of Resident #106's Brief Interview for Mental Status, dated 2/20/26, revealed a score of 15 which indicated she was cognitively intact. During an observation and interview on 02/22/2026 at 11:26 AM, Resident #106 was in her bed eating lunch. Resident #106 was served a salad that contained iceberg lettuce and tomatoes. On Resident #106's tray was a meal ticket (A slip of paper that noted the residents' diet order, likes, dislikes, and other meal information) that stated, .Only veggies (vegetables) preferred is (sic) broccoli, green beans and carrots. Resident #106 reported she hated tomatoes and didn't care for iceberg lettuce. Resident #106 confirmed the facility had taken down her preferences and they were accurate on the meal ticket. During an observation and interview on 02/23/2026 at 11:30 AM, Resident #106 was in her bed eating lunch. On Resident #106's tray was a meal ticket that stated, Dislikes: [NAME] bread and Only veggies (vegetables) preferred is (sic) broccoli, green beans and carrots. Resident #106 was served an open-faced turkey sandwich on white bread and mixed vegetables (which contained peas, corn, green beans, carrots, and lima beans). Resident #106 was observed pushing the lima beans off to the side of the plate. Resident #106 stated she gets a bit frustrated when she was served food items that were on her dislike list. Resident #91: Review of Resident #91's Brief Interview for Mental Status, dated 1/12/26, revealed a score of 12 which indicated moderate cognitive impairment. During an observation and interview on 02/23/2026 at 11:36 AM, Resident #91 was eating lunch in the main dining room. Resident #91 was served mixed vegetables (peas, corn, green beans, carrots, and lima beans) and her meal ticket stated, Dislikes: [NAME] peas .carrots .Beans. Resident #91 reported it makes her sick when she is given food on her dislikes list. Resident #91 proceeded to eat none of the mixed vegetables and pushed the bowl containing them away on the table with a grimace on her face. Review of Resident #91's nutrition care plan revealed an intervention, dated 5/28/2019, which stated, Provide diet preferences and offer substitutes as needed. Resident #31: During an observation and interview on 02/23/2026 at 11:41 AM, Resident #31 was eating lunch in the main dining room. Resident #31 was served mixed vegetables (peas, corn, green beans, carrots, and lima beans). Resident #31's meal ticket on the table stated, Dislikes: .Green Beans. Resident #31 reported she wouldn't eat them and left them untouched on her plate. Review of Resident #31's nutrition care plan revealed an intervention, dated 5/6/2025, which stated, Provide diet preferences and offer substitutes as needed.Resident #5: (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 02/23/2026 at 11:46 AM, Resident #5 was eating lunch in the main dining room. Resident #5 was served mixed vegetables (peas, corn, green beans, carrots, and lima beans). Resident #5's meal ticket on the table stated, Dislikes: .Green Peas. Resident #5 stated, I hate green peas .since I was 6 years old and reported it felt like nobody listens when asked how it made him feel to be served food on his dislike list. Resident #5 ate none of the mixed vegetables and left them untouched. Review of Resident #5's nutrition care plan revealed an intervention, dated 10/25/2025, which stated, Provide diet preferences and offer substitutes as needed. Review of the facility's Food Preferences policy, dated 1/9/25, stated, Food preferences will be identified on tray tickets to ensure residents are provided with appropriate food items. Resident #42 Review of an admission Record revealed Resident #42 was a female, with pertinent diagnoses which included depression and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #42, with a reference date of 12/11/25, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated she was cognitively intact. In an interview on 2/22/26 at 10:16 AM, Resident #42 reported concerns with the food served at the facility. Resident #42 reported some of the meals served are terrible due to the combinations of foods served and being served items that she dislikes. Resident #42 reported when this happens, she will not eat her meal and wait for the next meal to be served. Review of a current Care Plan for Resident #42 revealed the focus .at nutritional and/or dehydration risk R/T (related to): allergic to oranges, leaves over 25% of food uneaten at (mealtimes) . revised 12/6/25, with interventions which included .Provide diet preferences and offer substitutes as needed . initiated 8/9/20. Review of a Diet History/Food Preferences assessment for Resident #42, dated 12/11/25, revealed dislikes which included gravy and lima beans. Review of a Diet History/Food Preferences assessment for Resident #42, dated 9/12/25, revealed dislikes which included corn and lima beans. In an observation and interview on 2/23/26 at 10:51 AM, Resident #42 was served her lunch tray in her room. Noted Resident #42 was served an open-faced turkey sandwich, with mashed potatoes and gravy, along with mixed vegetables (a combination of peas, corn, green beans, carrots, and lima beans). Resident #42 stated .I won't eat it . and reported she did not like gravy or when food items are .all mixed up . Noted Resident #42's tray ticket listed multiple dislikes which included both gravy and mixed vegetables. In an observation and interview on 2/24/26 at 11:18 AM, Resident #42 was served her lunch tray in her room. Noted Resident #42 was served a beef taco with cheese and tomato, Spanish rice, and refried beans. Resident #42 referred to the Spanish rice and refried beans and stated .I don't like them . Noted Resident #42's tray ticket had a note which stated .no beans of any kind . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/24/26 at 1:44 PM, Dietary Manager QQ reported dietary preferences are assessed quarterly, with changes to preferences modified more frequently as needed. Dietary Manager QQ reported when meals are served, the cook would be responsible to reference the tray ticket (which lists diet orders, allergies, likes, and dislikes) for each resident prior to plating the meal to ensure residents are served items consistent with their diet and preferences.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) for Medicare Part A services in 2 residents (Resident #73 and #92) of 3 residents, reviewed for timely provision of notifications, resulting in the potential for the resident or resident representative to be unaware of changes regarding financial liability, frustration, and a delay in the ability to file an appeal. Findings include: Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE].Review of Resident #73's SNF (skilled nursing facility) Beneficiary Protection Notification Review revealed, .Last covered day of Part A Service: 11/12/25 .The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted .1. Was a SNF ABN, Form CMS-10055 provided to the resident? .No - if no, explain why the form was not provided: (no explanation recorded) .Review of an admission Record revealed Resident #92 was originally admitted to the facility on [DATE]. Review of Resident #92's SNF Beneficiary Protection Notification Review revealed, .Last covered day of Part A Service: 2/19/26 .The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted .1. Was a SNF ABN, Form CMS-10055 provided to the resident? .No - if no, explain why the form was not provided: (no explanation recorded) . In an interview on 02/23/2026 at 1:38 PM, Nursing Home Administrator (NHA) A reported that the above documents were accurate, and Resident #73 and #92 had not received the required ABN notifications. NHA A reported that the facility had recently hired a new Business Office Manager (BOM) that was responsible for providing notifications to residents when there was a change in their insurance benefits. In an interview on 02/24/2026 at 11:52 AM, BOM X reported that she had forgotten to issue ABN notifications when Resident #73 and #92 had a change in their benefits.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision for 1 (Resident #5) of 5 residents reviewed for accidents and falls, resulting in the potential for injury.Findings include:Resident #5Review of an admission Record revealed Resident #5 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: mild cognitive impairment of uncertain or unknown etiology (source) and history of falling.Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 1/15/2026 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #5 was moderately cognitively impaired (8-12 moderate cognitive impairment). Review of section J: Health Conditions Falls- indicated that Resident #5 had experienced falls since admission.Review of Care Plan for Resident #5 revealed Resident #5 is at risk for fall related injury and falls R/T (related to): Deconditioning, fear of falling, gait/balance problems, unsteady, impaired, history of falling. with interventions of encourage proper foot wear, keep resident's environment as safe as possible, provide activities that minimize the potential for falls while providing diversion and distractions, and call light within reach all initiated on 10/24/25. Care Plan was updated to include interventions of grippy socks to be worn as allowed and offer toileting before and after melas were added on 11/11/25. The last intervention added on 12/22/25 was to add a sign to Resident #5's walker to remind him to use it when ambulating (walking). Resident #5 had functional ability deficit and request assistance with self-care/mobility with interventions for transfers as resident requires supervision/touching assist with one helper initiated 11/3/25 and ambulation/walking resident requires supervision/touch assistance with 1 helper and a 4ww (4 wheeled walker) initiated on 2/18/26.Review of Kardex (a collection of interventions from the care plan in one location for ease of access by staff) accessed on 2/24/26 for Resident #5 revealed transferring resident requires supervision/touching assist with one helper, ambulation/walking resident requires supervision/touching assistance with one helper, 4WW resident continues to ambulate without assistance.On 2/22/26 at 9:45 AM Resident #5 was observed standing at the foot of his bed in his room and was manipulating the handles of his 4WW from the side as it was parked at the foot of the bed, while standing between the foot rests that were attached to his wheelchair as the urine collection bag connected to his catheter (a tube inserted into the bladder to drain urine) was still hanging from the bottom side of the wheelchair. There were unknown staff members present in the hallway, walking past his room with the door open and noted to be looking into the room as they passed. No staff members entered his room or acknowledged him. Resident sat down in his wheelchair after several minutes of standing. On 2/22/26 at 10:23 AM, Resident #5 was observed standing between the footrests on his wheelchair, in the doorway of his room, holding his urine collection bag in both hands. Resident #5 was noted to be unsteady, turning in circles, and at one point observed to be off balance and grabbed for the handrail attached to the wall outside of the room to steady himself. During this observation, an unknown staff member was observed sitting at the nurses' station at the end of the hallway and appeared to be observing Resident #5 while he was standing in the hallway. At 10:26 AM Licensed Practical Nurse (LPN) W was observed walking around and sitting at the nurse's station and looking down the hallway at Resident #5 who was still standing between the footrests on his wheelchair in the doorway to his room. Certified Nurse Assistant (CNA) II was observed walking around the nurse's station, stopping, turning to observe the hallway, and then continued to walk behind the nurse's station. Resident #5 was still standing in the hallway. None of the staff members attempted to intervene in any way with Resident #5 while he was standing in the hallway. Resident #5 sat in his wheelchair at 10:27 AM while still holding his urine collection bag.In a telephone interview on 2/22/26 at 11:25 AM, Family Member MM stated Resident #5 had several falls since he was admitted to the facility.Review of Resident #5's medical record indicated he had 5 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented falls since admission.In an interview on 2/23/26 at 1:24 PM, CNA II reported Resident #5 was independent for transfers and ambulation. CNA II reported sometimes he needed a little help, but not all the time. CNA II reported Resident #5 was a fall risk.In an interview on 2/23/26 at 1:42 PM, Unit Manager (UM) M reported Resident #5 had an unsteady gait, shuffles his feet sometimes when he walks and was a fall risk. UM M reported Resident #5 needed the assistance of one person for cares, but he could independently transfer. UM M reported sometimes Resident #5 would get stuck when transferring and he was unable to get his feet to keep moving in the direction his body was going. UM M reported Resident #5 was independent in his room with transfers and ambulation.In an interview on 2/24/26 at 8:42 AM, Occupational Therapist (OT) OO reported Resident #5 has a shuffling gait and had experienced a decline since December. OT OO reported Resident #5 was unsafe to transfer or ambulate independently and that was why he was on physical therapy services. OT OO reported if nursing staff says he can transfer and walk independently, they are wrong. He was a fall risk and requires touching when transferring and walking. In an interview on 2/24/26 at 10:49 AM LPN J reported Resident #5 had an unsteady gait, had falls in the past, was a fall risk, and needed standby/contact guard assistance. LPN J reported Resident #5 needed increased supervision as had recently declined in his ability to safety do things independently. In an interview on 2/24/26 at 1:30 PM, Physical Therapy Assistant (PTA) PP reported Resident #5 should not be up by himself, he was a fall risk, and that he was a one assist with a four wheeled walker with transfers and ambulation. PTA PP reported when Resident #5 was in his room he forgot he needed help, was impulsive, would not remember he needed to ask assistance and needed increased supervision related to safety. PTA PP reported Resident #5 definitely needed someone touching him when he was transferring or walking.In an interview on 2/24/26 at 1:55 PM, CNA I and CNA T reported Resident #5 had to have hands on assistance if he was doing any kind of transfer or walking. CNA T reported Resident #5 had a very unsteady gait and was very wobbly when standing.On 2/24/26 at 1:57 PM, CNA T retrieved a binder at the nurse's station and indicated it was a care plan update book. CNA T reported the binder was how the changes in a care plan for a resident was communicated to the staff. CNA T opened the book to a page for Resident #5 that was dated 2/18/26 and noted to have green highlighted marks emphasizing (when) ambulation/walking - Resident requires supervision/touch assistance with one helper, 4ww; Resident continues to ambulate without assistance.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that irregularities identified by the pharmacist were acted upon for 1 resident (Resident #2) of 5 residents, reviewed for unnecessary medications resulting in Resident #2 receiving an excessive dose of Escitalopram (antidepressant medication) and the potential for medication side effects including life threatening effects from QT (a measurement that shows the heart's electrical activity) prolongation (when the electrical system in your heart takes too long to recharge).Findings include:Review of an admission Record revealed Resident #2 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: schizophrenia (a serious mental health condition that results in a mix of hallucinations, delusions, and disorganized thinking and behavior) and bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme high episode to a low depressive episode). Review of a Minimum Data Set (MDS) assessment for Resident #2, with a reference date of 2/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #2 was cognitively intact. During an interview and observation on 02/22/2026 at 11:53 AM Resident #2 was in his room sitting in his wheelchair and refused to speak with this surveyor. In a subsequent interview on 02/23/2026 at 9:00 AM, Resident #2 willingly verbalized frustration with having to reside in the facility and that they (unknown people) were treating him wrong.In an interview on 02/24/2026 @ 12:44 PM, Social Worker (SW) D reported that she did not have any record of Resident #2's MRR (medication regimen review) by the pharmacist and was confident that Resident #2's medication had not been changed and there were no recommendations to be changed. SW D reported the BCS (behavioral care services) provider documents all changes in medications in a visit note and then usually sends an email to explain any changes. SW D reported that Resident #2's behaviors still vary and he continued to be hyper focused on his medications. SW D reported that she would not recommend any adjustments being made to his medications and trusted the BCS providers.In an interview on 02/24/2026 at 2:02 PM, Director of Nursing (DON) B reported that she had located Resident #2's Medication Regimen Review (MRR) report from December 2025 but was not able to find the corresponding irregularities report.Review of Resident #2's Medication Regimen Review (MRR) dated 12/16/25 indicated that there was a report attached that explained irregularities and/or recommendations.In a subsequent interview on 02/24/2026 at 2:27 PM, DON B reported that she had located the December MRR recommendations from the pharmacist, which were to decrease Resident #2's Escitalopram from 20 mg to 10 mg. DON B reported that the facility provider had not acknowledged the recommendations but that the BCS provider notes indicated that Resident #2 had been receiving an incorrect dose of Escitalopram while in the hospital in November 2025 and that it was continued when the resident returned to the facility. DON B further reported that Resident #2's current physician orders for Escitalopram were still 20 mg and had not changed since he returned from the hospital on [DATE]. Review of Resident #2's Note to Attending Physician/Prescriber dated 12/16/25 revealed, (Resident #2) is receiving Lexapro (Escitalopram) 20 mg daily, which exceeds the maximum recommended daily dose of Escitalopram 10 mg daily in those over [AGE] years of age. Recommendation: Please decrease to 10 mg daily, while concurrently monitoring for reemergence of depression and/or withdrawal symptoms. If symptoms emerge, alternative therapy may be warranted. Rationale for recommendation: Due to the risk of QT prolongation, Escitalopram 10 mg per day is the maximum recommended dose for individuals who are older than [AGE] years of age. If Escitalopram is to continue at this dose, it is recommended that the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual . This document did not include a physician/provider response. Review of Resident #2's current Medication Orders revealed, Escitalopram Oxalate Oral Tablet 10 mg, give 2 tablets by mouth on time a day for Bipolar, Active 11/10/2025 at 4:00 AM.

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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 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 (continued on next page)

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	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2713932Based on interview and record review, the facility failed to ensure accurate documentation in a medical record for 2 (Resident #29 and #2) of 18 residents reviewed for accurate medical records, resulting in inaccurate documentation of the services provided and inaccurate physician notes. Findings include:Resident #29 Review of an admission Record revealed Resident #29 was a female who was originally admitted to the facility on [DATE] and 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, 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) Oral Tablet 10 mg (Milligram) 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 2:39 PM, Resident #29 reported the facility did not have her medication in the building, the pharmacy would not send it, and for a few days in January 2026 and staff were 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. 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 Licensed Practical Nurse (LPN) O for Resident #29 revealed . needs new script (prescription). Physician aware. 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. 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, and 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 the MAR for Resident #29 revealed documentation on 1/11/26 by LPN V that indicated (continued on next page)

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident #29 received her ordered oxycodone 10 mg tablet at bedtime. Review of Transactions by Patient ID for the back-up medication box at the facility for Resident #29 revealed oxycodone IR (Immediate Release) 10 mg was pulled from backup for Resident #29 on 1/9/26 at 1:55 am and no tablet was pulled for administration on 1/11/26. Multiple attempts to contact LPN V were unsuccessful, and no interview was conducted by the time of survey exit. Review of Packing Slip revealed (Name Redacted) pharmacy delivered 15 tablets of Oxycodone 10 mg for Resident #29 on 1/13/26. In an interview on 2/24/26 at 10:53 AM Director of Nursing (DON) B confirmed that Resident #29 was given the last tablet of her oxycodone 10 mg supply on 1/6/26, documentation indicated that Resident #29's oxycodone 10 mg was held (not given) on 1/8/26, no documentation was noted indicating Resident #29 received a dose of 10 mg oxycodone late on 1/8/26. DON B reported documentation indicated that Resident #29 was given her scheduled dose of oxycodone 10 mg on 1/11/26, but DON B was unable to determine where the medication tablet came from. 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 stated It appears Resident #29 did not get a dose on 1/11/26, even though it was documented she did. DON B confirmed that the documentation was inaccurate. Review of an admission Record revealed Resident #2 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: schizophrenia (a serious mental health condition that results in a mix of hallucinations, delusions, and disorganized thinking and behavior) and bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme high episode to a low depressive episode). Review of Resident #2's current Physician Orders revealed, Escitalopram Oxalate (antidepressant medication) Oral Tablet 10 mg, give 2 tablets (total of 20 mg) by mouth one time a day for Bipolar, Active 11/10/2025 at 4:00 AM. In an interview on 02/24/2026 at 2:27 PM, Director of Nursing (DON) B reported that Resident #2's current physician orders for Escitalopram were for two 10 mg pills (20 mg total) and had not changed since he returned from the hospital on [DATE]. DON B reported that prior to Resident #2's hospitalization he had been taking 10 mg of Escitalopram. Review of Resident #2's Provider Visit notes from 11/9/25 to the most recent visit on 2/19/2026 related to the management of his Escitalopram revealed, . Medication list: .Escitalopram oxalate oral tablet 10 mg, give 1 tablet (total of 10 mg) by mouth one time a day for bipolar disorder .Active 3/20/25 This medication list, including dose and frequency, is taken from the facility where patient resides and reflects the best information available at the time of the encounter .Patient is seen today by provider for chronic condition management review f/u (follow up). Detailed chart review, medication review, labs, vital signs, nursing notes, IDT (intradisciplinary) notes reviewed. Nursing denies any concerns at this time .Schizoaffective disorder, bipolar type . It was noted that this information was inconsistent with Resident #2's current physician orders for Escitalopram.