STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235299	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Bedford (the)	270 N Bedford Rd Battle Creek, MI 49017

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 This citation pertains to Intake #MI00149504 Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act 42CFR483. 12(c) Findings include Resident #1 (R1) Review of the medical record reflected R1 was an initial admission to the facility on [DATE]. Diagnoses of unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing, difficulty with walking, Type 2 Diabetes Mellitus, and history of falling. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/2024, revealed R1 had a Brief Interview of Mental Status (BIMS) of 11 out of 0 to 15 being (moderate cognitive impairment). Under section G0100, Activities of Daily Living (ADL) Assistance reveals R1 needs set up assistance for meals and oral hygiene. R1 requires substantial to maximum assistance with showers, toileting, and getting dressed. During an interview and observation on 01/22/25 at 8:24 AM, R1 was eating breakfast in her room. R1 was sitting in her wheelchair with the over the bed table in front of her. R1 stated that R9 hit her and added that he hit her on the left arm that was broken. R1 stated she was sitting in her wheelchair, out in the hallway. R1 then stated R9 moves around the facility in his wheelchair. R1 then stated R9 rolled his wheelchair up to hers and purposefully hit her a couple of times in the left arm. R1 stated that it startled her, and it hurt where R9 hit her. (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	During an interview on 01/22/25 at 11:30 AM with LNA A, writer asked for the incident report and investigation on the resident-to-resident incident on 01/09/25 between R1 and R 9. LNA A stated he had started one yesterday as writer entered the building and would go get it. Upon reading the incident report, it was as followed: Incident Description reads, another resident made contact with this resident left shoulder. Doctor notified and a shoulder Xray was ordered due to it being the shoulder that was post-op. Under section was this incident witnessed: Patient stated that she was experiencing no increased pain in shoulder. Stated that she does not feel the other resident hit her on purpose. Incident report completed by Licensed Practical Nurse (LPN) G. Writer asked LNA A if he reported this incident of resident to resident to the state, and he stated no. During an interview on 01/22/25 at 12:08PM, LPN G stated that R9 had come up to R1 and purposefully hit her a couple of times in the left shoulder. LPN G stated R1 complained of pain, and the Nurse Practitioner (NP) L was still in the building, and she came over to assess R1. LPN G stated the process is to make sure both residents are safe, contact LNA A then go through the incident report. LPN G stated, they look at new interventions to prevent it from happening again. LPN G stated R1 was sitting in her wheelchair up by the nurse's station because she was a fall risk. LPN G also stated they changed R1's room so she would not be close to R9, however R9's room was not changed. LPN G stated she re-assessed R1 and it should be documented in the nursing progress notes. LPN G also stated they usually assess residents for 3 days and they were assessing that area due to R1 still having staples in arm. LPN G also stated that R1 did have left arm/shoulder pain following the incident, but by the time she started to fill out the incident report, R1 was no longer having pain in the left arm/shoulder. Record review did not reveal a nursing progress note on this incident from LPN G. No nursing progress notes on this incident from any nursing staff caring for R1. NP L documented R1's . This is a [AGE] year-old female patient being seen today at the request of nursing staff for an altercation involving another resident. The other resident (R9) approached the patient (R1) and then struck the patient on her left injured arm. The patient was very upset and painful. Vital signs were completed, all within range. Her left arm is in a sling. She has staples on her left shoulder from her surgery. The staples are intact and no redness or oozing and no visible edema or ecchymosis. Reevaluated patient prior to leaving for the day and no changes. Pain is managed. Her vital signs are stable . Continue to monitor for increased pain. May need to perform an x-ray after altercation with other residents . During an interview on 01/23/25 at 12:06 PM, LNA A stated R9 goes all over the place in the facility. LNA A stated he was told R9 hit R1 in the shoulder, nurse asked LNA A to come down to the unit. LNA A stated R1 was startled, she told LNA A she was hit, it scared her. LNA A stated that it seemed like it was more of R9 seeking attention kind of thing verses being harmful on the other residents (R1) end. LNA A stated he let the doctor know, didn't see any bruising on her, so they moved her off that hall, to get her closer to the nursing station and away from him (R9). LNA A then stated, this specific incident, no injury, or intent. Writer asked LNA A if the incident was investigated, he stated yes, stated they put interventions in place. Writer asked to see the investigation. Record review revealed R1 had an X-Ray since this was a fresh surgical left arm that was hit.FINDINGS: There is postoperative change with a side plate and screws at the proximal humerus. Fracture alignment maintained. CONCLUSION: Postoperative changes . (continued on next page)

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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	During an interview on 01/23/25 at 12:30 PM, Unit Manager/RN F stated her and other nurse in her office, Minimum Data Set (MDS) Nurse K stated the changes to interventions would not be on R1's care plan as she didn't do anything wrong, it would be on R9's care plan. During this same interview, MDS Nurse K also stated that R9 cannot go off his unit without supervision. MDS Nurse K added that they cannot stop him from going where he wants to go within the facility, but he would have a supervision with him. Record review of the incident report on the resident-to-resident incident was not completed, areas were left blank and unanswered. It did not mention the fact that R1 had an x-ray ordered for the left shoulder due to the incident and pain in that area. The report did not reflect the results of the X-rays. Writer request for the investigation that went along with the incident report was never provided before the exit of the survey. This resident to resident incident was not investigated or reported to the state. Resident #9 (R9) Review of the medical record reflected R9 was an initial admission to the facility on [DATE]. Diagnoses of Pericardial Effusion, Difficulty walking, Unspecified lack of expected normal Physiological Development in Childhood, Brief Psychotic Disorder, Anxiety, Unspecified Speech Disturbances. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/ 23 /2024, revealed R9 functions at a 9-year-old child. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R9 is dependent of all care. During an interview and observation on 01/22/25 at 8:24 AM, R1 was eating breakfast in her room. R1 was sitting in her wheelchair with the over the bed table in front of her. R1 stated that R9 hit her and added that he hit her on the left arm that was broken. R1 stated she was sitting in her wheelchair and sitting out in the hallway. R1 then stated R9 rolled his wheelchair up to hers and purposefully hit her a couple of times in the left arm. R1 stated that it startled her, and it hurt where R9 hit her. During an interview on 01/22/25 at 11:30 AM with LNA A, writer asked for the incident report and investigation on the resident-to-resident incident on 01/09/25 between R1 and R 9. LNA A stated he had started one yesterday as writer entered the building and would go get it. Upon reading the incident report, it was as followed: Incident Description reads, another resident made contact with this resident left shoulder. Doctor notified and a shoulder Xray was ordered due to it being the shoulder that was post-op. Under section was this incident witnessed: Patient stated that she was experiencing no increased pain in shoulder. Stated that she does not feel the other resident hit her on purpose. Incident report completed by Licensed Practical Nurse (LPN) G. Writer asked LNA A if he reported this incident of resident to resident to the state, and he stated no. (continued on next page)

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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	During an interview on 01/22/25 at 12:08PM, LPN G stated that R9 had come up to R1 and hit her a couple of times in the left shoulder. LPN G stated R1 complained of pain, and the Nurse Practitioner (NP) L was still in the building, and she came over to assess R1. LPN G stated the process is to make sure both residents are safe, contact LNA A then go through the incident report. LPN G stated R1 did have pain from the hitting of her left shoulder. LPN G stated they look for new interventions, to prevent it from happening again. LPN G stated R1 was sitting up by the nurse's station because she was a fall risk. LPN G also stated they changed R1's room so she would not be close to R9, however R9's room was not changed. LPN G stated she re-assessed R1 and it should be documented in the nursing progress notes. LPN G also stated they usually assess residents for 3 days and they were assessing that area due to R1 still having staples in arm. Record review did not reveal a nursing progress note on this incident from LPN G. No nursing progress notes on this incident from any nursing staff caring for R1. NP L documented R1's . This is a [AGE] year-old female patient being seen today at the request of nursing staff for an altercation involving another resident. The other resident (R9) approached the patient (R1) and then struck the patient on her left injured arm. The patient was very upset and painful. Vital signs were completed, all within range. Her left arm is in a sling. She has staples on her left shoulder from her surgery. The staples are intact and no redness or oozing and no visible edema or ecchymosis. Reevaluated patient prior to leaving for the day and no changes. Pain is managed. Her vital signs are stable . Continue to monitor for increased pain. May need to perform an x-ray after altercation with other residents . During an interview on 01/23/25 at 12:06 PM, LNA A stated R9 goes down all the halls in the facility. LNA A stated he was told R9 hit R1 in the shoulder, nurse asked LNA A to come down to the unit. LNA A stated R1 was startled, she told LNA A she was hit, it scared her. LNA A stated that it seemed like it was more of R9 seeking attention kind of thing verses being harmful on the other residents (R1) end. LNA A stated he let the doctor know, didn't see any bruising on her, so they moved her off that hall, to get her closer to the nursing station and away from him. LNA A then stated, this specific incident, no injury, or intent. Writer asked LNA A if the incident was investigated, he stated yes, stated they put interventions in place. Writer asked to see the investigation. During an interview on 01/23/25 at 12:30 PM, Unit Manager/RN F stated. Her and other nurse in her office, Minimum Data Set (MDS) Nurse K stated the changes to interventions would not be on R1's care plan as she didn't do anything wrong, it would be on R9's care plan. During this same interview, (MDS) Nurse K also stated that R9 cannot go off his unit without supervision. MDS Nurse K added that they cannot stop him from going where he wants to go within the facility, but he would have a supervision with him. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R9's care plan revealed under Need: R9 had an actual behavior problem R/T: Patient will pinch, hit and kick. Patient will throw items such as remote and silverware during mealtimes. Patient will put self onto floor. Per guardian, patient will sit on the floor per preference. Guest will lay down on the floor when he is tired Date Initiated: 12/26/2024, Revision on: 01/04/2025. Under Goal: Patient will have fewer episodes of behaviors by review date. 12/26/2024, Target Date: 02/06/2025. Under Interventions: Guest needs plastic silverware no knives, 2-person care for ADL's. If patient get combative, ensure patient is safe and reapproach. Patient likes to hug and expresses emotion through hands. Will sometimes touch without meaning harm. Redirect resident. Document behaviors, and resident response to interventions. Ensure resident doesn't get in reach of other residents during increased supervision during waking hours. Move guest to lower stimulus environment when guest becomes agitated. Offer to wheel resident around facility as this is calming to him. Set firm boundaries and let patient know this is not appropriate behavior. Record review of a nursing progress note reported dated 12/29/2024 at 5:29PM, Behavior Note Text . Throughout the day resident was sitting at nurses' station and staff was watching his iPad with him. He was happy and calm and cooperative at this time of watching it with him. While in the middle of his show he became upset and started to grab this nurse's arm scratching her, hitting her, and attempting to bite her. Staff offered toys/games/movies in his room. He again was cooperative with nurse playing with his toys with him when he again lashed out and took the toy and struck the nurse in the head/shoulder. He then proceeded to run up the hallway knocking off papers, phones, med cups, gloves, iso carts, chairs down. He was not able to be redirected, and all interventions were exhausted. Staff administered compound medication of Ativan, Benadryl and Haldol (ABH) cream. This was only mildly effective. He has had outburst throughout the entire day of this caliber. Staff had notified on call manager and administrator of his behaviors. He does calm with time but will repeat this behavior . Record review of a nursing progress note reported dated 12/30/2024 at 3:23 PM, Resident left to go to [NAME] Battle Creek (BBC) emergency room (ER) for evaluation/treatment related to behavioral symptoms and aggression towards staff. Patient left facility on stretcher with Emergency Medical System (EMS). Record review of a social work progress note reported dated 12/30/2024 at 4:27 PM, Guardian informed patient petition for inpatient psych sent to BBC for behaviors and aggression towards others. Guardian would like for patient to go to inpatient psych. Rapport with BBC social worker given. Record review of a nursing progress note reported dated 12/30/2024 at 6:06 PM, Resident arrived back to facility. No new orders at this time. Record review of a nursing progress note reported dated 1/4/2025 at10:39 PM, Guest walking around the unit and upset because his tablet is not charged, however staff has been plugging it in and he will immediately unplug it and use it until the battery dies. Guest throwing stuff on the unit pulling things off the wall, grabbing and pinching staff attempts to redirect unsuccessful, ABHR cream applied, and guest settled down laying on the floor trying to sleep, staff attempted to get guest to bed and guest declined, guest made safe on the floor per his preference and continued to encourage guest to lay down in bed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a nursing progress note reported dated on 1/9/2025 at 4:01AM, Guest was aggressive with staff at the beginning of the shift this evening. He was choosing to throw items around the nurse's station, throw pens at the nurse, and hit the nurse with closed hands. After multiple attempts by staff, he eventually calmed himself with the help of his tablet and sat on his bed watching television. He has been up periodically throughout the night with no further issues. Record review of a nursing progress note reported dated 1/19/2025 00:00 Telehealth - Nurse states that guest is still not sleeping, he does have anxiety and is having a rough night. He is pacing and running up and down the hallways, hitting the wall, and just unable to be calmed. He is already on melatonin 10mg and 0. 5mg of Ativan and neither are helping. Advised to give trazodone 50mg x1. Update: nurse reports that script was effective. Record review of a nursing progress note reported dated 1/19/2025 at 02:00 AM, Behavior Note: Guest has struggled this shift to regulate his emotions. He has been anxious and running about the facility with staff close behind. He is expressing desire to go home but is not seeking exit. This nurse gave his PRN dose of Ativan without relief and was able to obtain a one-time order for trazodone 50mg which was effective and allowed him to rest. Phone call was placed to guardian with no answer. Administrator and on call nurse notified. Record review of a nursing progress note dated 1/20/2025 at 4:11pm, Patient has been extremely agitated and physically & verbally aggressive this shift. He has been screaming, running through hallway, throwing things off the nurse's desk, knocking things over, slamming his room and other patient's room doors. He bit this nurse on the breast, abdomen, and arm. Several attempts were made to redirect patient and were ineffective. PRN ABH gel was administered and unsuccessful. Patient then began to hit himself in head and bang head against wall. No injuries were noted. Patient hit, bit, and pinched several other staff members. Management was notified of this. Patient was eventually calmed down and given different options to keep him entertained such as coloring pages, a blow-up set of dice, and playing catch with staff. Record review of a nursing progress note reported dated 1/22/2025 at12:49 PM, Patient grabbed this nurse by the hand, breaking the skin. He then knocked over desktop computer multiple times, tried knocking over printer, and repeatedly slammed bedroom door. Redirection was unsuccessful, PRN ABH gel applied. Patient is now sitting watching tablet in chair near nurse's desk. Record review did not reflect any new interventions added to R9's care plan following the resident-to-resident altercation between R1 and R9 on 01/09/2025. Care plan was not updated following any of the behavioral incidents from 12/30/2024 through 01/22/2025. Care goal was updated to 02/06/2025. Record review of progress notes did not reflect any documentation of the resident-to-resident altercations between R9 and R1 on 01/09/2025 in his medical records. Nor did it reflect any new interventions placed in his care plan to protect other residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 This citation pertains to Intake #MI00149504 Based on interview and record review the facility failed to thoroughly investigate allegations of abuse for one of two residents (R1, R9) reviewed for abuse from a total sample of nine; resulting in known allegations of abuse to go uninvestigated and the potential for abuse to occur with no intervention or protection. Findings include: Resident #1 (R1) Review of the medical record reflected R1 was an initial admission to the facility on [DATE]. Diagnoses of unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing, difficulty with walking, Type 2 Diabetes Mellitus, and history of falling. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/2024, revealed R1 had a Brief Interview of Mental Status (BIMS) of 11 out of 0 to 15 being (moderate cognitive impairment). Under section G0100, Activities of Daily Living (ADL) Assistance reveals R1 needs set up assistance for meals and oral hygiene. R1 requires substantial to maximum assistance with showers, toileting, and getting dressed. During an interview and observation on 01/22/25 at 8:24 AM, R1 was eating breakfast in her room. R1 was sitting in her wheelchair with the over the bed table in front of her. R1 stated that R9 hit her and added that he hit her on the left arm that was broken. R1 stated she was sitting in her wheelchair, out in the hallway. R1 then stated R9 moves around the facility in his wheelchair. R1 then stated R9 rolled his wheelchair up to hers and purposefully hit her a couple of times in the left arm. R1 stated that it startled her, and it hurt where R9 hit her. During an interview on 01/22/25 at 11:30 AM with LNA A, writer asked for the incident report and investigation on the resident-to-resident incident on 01/09/25 between R1 and R 9. LNA A stated he had started one yesterday as writer entered the building and would go get it. Upon reading the incident report, it was as followed: Incident Description reads, another resident made contact with this resident left shoulder. Doctor notified and a shoulder Xray was ordered due to it being the shoulder that was post-op. Under section was this incident witnessed: Patient stated that she was experiencing no increased pain in shoulder. Stated that she does not feel the other resident hit her on purpose. Incident report completed by Licensed Practical Nurse (LPN) G. Writer asked LNA A if he reported this incident of resident to resident to the state, and he stated no. (continued on next page)

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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	During an interview on 01/22/25 at 12:08PM, LPN G stated that R9 had come up to R1 and purposefully hit her a couple of times in the left shoulder. LPN G stated R1 complained of pain, and the Nurse Practitioner (NP) L was still in the building, and she came over to assess R1. LPN G stated the process is to make sure both residents are safe, contact LNA A then go through the incident report. LPN G stated, they look at new interventions to prevent it from happening again. LPN G stated R1 was sitting in her wheelchair up by the nurse's station because she was a fall risk. LPN G also stated they changed R1's room so she would not be close to R9, however R9's room was not changed. LPN G stated she re-assessed R1 and it should be documented in the nursing progress notes. LPN G also stated they usually assess residents for 3 days and they were assessing that area due to R1 still having staples in arm. LPN G also stated that R1 did have left arm/shoulder pain following the incident, but by the time she started to fill out the incident report, R1 was no longer having pain in the left arm/shoulder. Record review did not reveal a nursing progress note on this incident from LPN G. No nursing progress notes on this incident from any nursing staff caring for R1. NP L documented R1's . This is a [AGE] year-old female patient being seen today at the request of nursing staff for an altercation involving another resident. The other resident (R9) approached the patient (R1) and then struck the patient on her left injured arm. The patient was very upset and painful. Vital signs were completed, all within range. Her left arm is in a sling. She has staples on her left shoulder from her surgery. The staples are intact and no redness or oozing and no visible edema or ecchymosis. Reevaluated patient prior to leaving for the day and no changes. Pain is managed. Her vital signs are stable . Continue to monitor for increased pain. May need to perform an x-ray after altercation with other residents . During an interview on 01/23/25 at 12:06 PM, LNA A stated R9 goes all over the place in the facility. LNA A stated he was told R9 hit R1 in the shoulder, nurse asked LNA A to come down to the unit. LNA A stated R1 was startled, she told LNA A she was hit, it scared her. LNA A stated that it seemed like it was more of R9 seeking attention kind of thing verses being harmful on the other residents (R1) end. LNA A stated he let the doctor know, didn't see any bruising on her, so they moved her off that hall, to get her closer to the nursing station and away from him (R9). LNA A then stated, this specific incident, no injury, or intent. Writer asked LNA A if the incident was investigated, he stated yes, stated they put interventions in place. Writer asked to see the investigation. Record review revealed R1 had an X-Ray since this was a fresh surgical left arm that was hit.FINDINGS: There is postoperative change with a side plate and screws at the proximal humerus. Fracture alignment maintained. CONCLUSION: Postoperative changes . During an interview on 01/23/25 at 12:30 PM, Unit Manager/RN F stated her and other nurse in her office, Minimum Data Set (MDS) Nurse K stated the changes to interventions would not be on R1's care plan as she didn't do anything wrong, it would be on R9's care plan. During this same interview, MDS Nurse K also stated that R9 cannot go off his unit without supervision. MDS Nurse K added that they cannot stop him from going where he wants to go within the facility, but he would have a supervision with him. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the incident report on the resident-to-resident incident was not completed, areas were left blank and unanswered. It did not mention the fact that R1 had an x-ray ordered for the left shoulder due to the incident and pain in that area. The report did not reflect the results of the X-rays. Writer request for the investigation that went along with the incident report was never provided before the exit of the survey. This resident to resident incident was not investigated or reported to the state. Resident #9 (R9) Review of the medical record reflected R9 was an initial admission to the facility on [DATE]. Diagnoses of Pericardial Effusion, Difficulty walking, Unspecified lack of expected normal Physiological Development in Childhood, Brief Psychotic Disorder, Anxiety, Unspecified Speech Disturbances. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/ 23 /2024, revealed R9 functions at a 9-year-old child. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R9 is dependent of all care. During an interview and observation on 01/22/25 at 8:24 AM, R1 was eating breakfast in her room. R1 was sitting in her wheelchair with the over the bed table in front of her. R1 stated that R9 hit her and added that he hit her on the left arm that was broken. R1 stated she was sitting in her wheelchair and sitting out in the hallway. R1 then stated R9 rolled his wheelchair up to hers and purposefully hit her a couple of times in the left arm. R1 stated that it startled her, and it hurt where R9 hit her. During an interview on 01/22/25 at 11:30 AM with LNA A, writer asked for the incident report and investigation on the resident-to-resident incident on 01/09/25 between R1 and R 9. LNA A stated he had started one yesterday as writer entered the building and would go get it. Upon reading the incident report, it was as followed: Incident Description reads, another resident made contact with this resident left shoulder. Doctor notified and a shoulder Xray was ordered due to it being the shoulder that was post-op. Under section was this incident witnessed: Patient stated that she was experiencing no increased pain in shoulder. Stated that she does not feel the other resident hit her on purpose. Incident report completed by Licensed Practical Nurse (LPN) G. Writer asked LNA A if he reported this incident of resident to resident to the state, and he stated no. During an interview on 01/22/25 at 12:08PM, LPN G stated that R9 had come up to R1 and hit her a couple of times in the left shoulder. LPN G stated R1 complained of pain, and the Nurse Practitioner (NP) L was still in the building, and she came over to assess R1. LPN G stated the process is to make sure both residents are safe, contact LNA A then go through the incident report. LPN G stated R1 did have pain from the hitting of her left shoulder. LPN G stated they look for new interventions, to prevent it from happening again. LPN G stated R1 was sitting up by the nurse's station because she was a fall risk. LPN G also stated they changed R1's room so she would not be close to R9, however R9's room was not changed. LPN G stated she re-assessed R1 and it should be documented in the nursing progress notes. LPN G also stated they usually assess residents for 3 days and they were assessing that area due to R1 still having staples in arm. (continued on next page)

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	235299	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Bedford (the)	270 N Bedford Rd Battle Creek, MI 49017

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review did not reveal a nursing progress note on this incident from LPN G. No nursing progress notes on this incident from any nursing staff caring for R1. NP L documented R1's . This is a [AGE] year-old female patient being seen today at the request of nursing staff for an altercation involving another resident. The other resident (R9) approached the patient (R1) and then struck the patient on her left injured arm. The patient was very upset and painful. Vital signs were completed, all within range. Her left arm is in a sling. She has staples on her left shoulder from her surgery. The staples are intact and no redness or oozing and no visible edema or ecchymosis. Reevaluated patient prior to leaving for the day and no changes. Pain is managed. Her vital signs are stable . Continue to monitor for increased pain. May need to perform an x-ray after altercation with other residents . During an interview on 01/23/25 at 12:06 PM, LNA A stated R9 goes down all the halls in the facility. LNA A stated he was told R9 hit R1 in the shoulder, nurse asked LNA A to come down to the unit. LNA A stated R1 was startled, she told LNA A she was hit, it scared her. LNA A stated that it seemed like it was more of R9 seeking attention kind of thing verses being harmful on the other residents (R1) end. LNA A stated he let the doctor know, didn't see any bruising on her, so they moved her off that hall, to get her closer to the nursing station and away from him. LNA A then stated, this specific incident, no injury, or intent. Writer asked LNA A if the incident was investigated, he stated yes, stated they put interventions in place. Writer asked to see the investigation. During an interview on 01/23/25 at 12:30 PM, Unit Manager/RN F stated. Her and other nurse in her office, Minimum Data Set (MDS) Nurse K stated the changes to interventions would not be on R1's care plan as she didn't do anything wrong, it would be on R9's care plan. During this same interview, (MDS) Nurse K also stated that R9 cannot go off his unit without supervision. MDS Nurse K added that they cannot stop him from going where he wants to go within the facility, but he would have a supervision with him. Record review of R9's care plan revealed under Need: R9 had an actual behavior problem R/T: Patient will pinch, hit and kick. Patient will throw items such as remote and silverware during mealtimes. Patient will put self onto floor. Per guardian, patient will sit on the floor per preference. Guest will lay down on the floor when he is tired Date Initiated: 12/26/2024, Revision on: 01/04/2025. Under Goal: Patient will have fewer episodes of behaviors by review date. 12/26/2024, Target Date: 02/06/2025. Under Interventions: Guest needs plastic silverware no knives, 2-person care for ADL's. If patient get combative, ensure patient is safe and reapproach. Patient likes to hug and expresses emotion through hands. Will sometimes touch without meaning harm. Redirect resident. Document behaviors, and resident response to interventions. Ensure resident doesn't get in reach of other residents during increased supervision during waking hours. Move guest to lower stimulus environment when guest becomes agitated. Offer to wheel resident around facility as this is calming to him. Set firm boundaries and let patient know this is not appropriate behavior. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a nursing progress note reported dated 12/29/2024 at 5:29PM, Behavior Note Text . Throughout the day resident was sitting at nurses' station and staff was watching his iPad with him. He was happy and calm and cooperative at this time of watching it ith him. While in the middle of his show he became upset and started to grab this nurse's arm scratching her, hitting her, and attempting to bite her. Staff offered toys/games/movies in his room. He again was cooperative with nurse playing with his toys with him when he again lashed out and took the toy and struck the nurse in the head/shoulder. He then proceeded to run up the hallway knocking off papers, phones, med cups, gloves, iso carts, chairs down. He was not able to be redirected, and all interventions were exhausted. Staff administered compound medication of Ativan, Benadryl and Haldol (ABH) cream. This was only mildly effective. He has had outburst throughout the entire day of this caliber. Staff had notified on call manager and administrator of his behaviors. He does calm with time but will repeat this behavior . Record review of a nursing progress note reported dated 12/30/2024 at 3:23 PM, Resident left to go to [NAME] Battle Creek (BBC) emergency room (ER) for evaluation/treatment related to behavioral symptoms and aggression towards staff. Patient left facility on stretcher with Emergency Medical System (EMS). Record review of a social work progress note reported dated 12/30/2024 at 4:27 PM, Guardian informed patient petition for inpatient psych sent to BBC for behaviors and aggression towards others. Guardian would like for patient to go to inpatient psych. Rapport with BBC social worker given. Record review of a nursing progress note reported dated 12/30/2024 at 6:06 PM, Resident arrived back to facility. No new orders at this time. Record review of a nursing progress note reported dated 1/4/2025 at10:39 PM, Guest walking around the unit and upset because his tablet is not charged, however staff has been plugging it in and he will immediately unplug it and use it until the battery dies. Guest throwing stuff on the unit pulling things off the wall, grabbing and pinching staff attempts to redirect unsuccessful, ABHR cream applied, and guest settled down laying on the floor trying to sleep, staff attempted to get guest to bed and guest declined, guest made safe on the floor per his preference and continued to encourage guest to lay down in bed. Record review of a nursing progress note reported dated on 1/9/2025 at 4:01AM, Guest was aggressive with staff at the beginning of the shift this evening. He was choosing to throw items around the nurse's station, throw pens at the nurse, and hit the nurse with closed hands. After multiple attempts by staff, he eventually calmed himself with the help of his tablet and sat on his bed watching television. He has been up periodically throughout the night with no further issues. Record review of a nursing progress note reported dated 1/19/2025 00:00 Telehealth - Nurse states that guest is still not sleeping, he does have anxiety and is having a rough night. He is pacing and running up and down the hallways, hitting the wall, and just unable to be calmed. He is already on melatonin 10mg and 0. 5mg of Ativan and neither are helping. Advised to give trazodone 50mg x1. Update: nurse reports that script was effective. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a nursing progress note reported dated 1/19/2025 at 02:00 AM, Behavior Note: Guest has struggled this shift to regulate his emotions. He has been anxious and running about the facility with staff close behind. He is expressing desire to go home but is not seeking exit. This nurse gave his PRN dose of Ativan without relief and was able to obtain a one-time order for trazodone 50mg which was effective and allowed him to rest. Phone call was placed to guardian with no answer. Administrator and on call nurse notified. Record review of a nursing progress note dated 1/20/2025 at 4:11pm, Patient has been extremely agitated and physically & verbally aggressive this shift. He has been screaming, running through hallway, throwing things off the nurse's desk, knocking things over, slamming his room and other patient's room doors. He bit this nurse on the breast, abdomen, and arm. Several attempts were made to redirect patient and were ineffective. PRN ABH gel was administered and unsuccessful. Patient then began to hit himself in head and bang head against wall. No injuries were noted. Patient hit, bit, and pinched several other staff members. Management was notified of this. Patient was eventually calmed down and given different options to keep him entertained such as coloring pages, a blow-up set of dice, and playing catch with staff. Record review of a nursing progress note reported dated 1/22/2025 at12:49 PM, Patient grabbed this nurse by the hand, breaking the skin. He then knocked over desktop computer multiple times, tried knocking over printer, and repeatedly slammed bedroom door. Redirection was unsuccessful, PRN ABH gel applied. Patient is now sitting watching tablet in chair near nurse's desk. Record review did not reflect any new interventions added to R9's care plan following the resident-to-resident altercation between R1 and R9 on 01/09/2025. Care plan was not updated following any of the behavioral incidents from 12/30/2024 through 01/22/2025. Care goal was updated to 02/06/2025. Record review of progress notes did not reflect any documentation of the resident-to-resident altercations between R9 and R1 on 01/09/2025 in his medical records. Nor did it reflect any new interventions placed in his care plan to protect other residents.