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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>235302 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>01/16/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Laurels of Coldwater,the |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>90 N Michigan Ave<br>Coldwater, MI 49036 |  |

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

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49272</p> <p>This is related to MI00148888</p> <p>Based on observation, interview and record review the facility failed to immediately report abuse allegations for one resident (R203) of two reviewed for abuse, resulting in allegations of abuse that were not reported to the Nursing Home Administrator (NHA) and the State Agency timely and the potential for further allegations of abuse to go unreported.</p> <p>Findings include:</p> <p>A review of intake MI00148888 submitted to the state agency revealed in part:</p> <p>What allegedly occurred: On the evening of 11/26/2024, (LPN G) was attempting to assist resident (R203) in his room on the memory care unit. (CNA K) was present. LPN G entered the room and told (R203) she needed to take care of his bloody nose, he had at the time. (CNA K) states that (LPN G) raised her voice when she informed (R203) and walked towards him. (R203) told (LPN G) Stay away from me! Several times. (R203) then yelled, Get the f*ck out of my room! (CNA K) reports (R203) grabbed (LPN G)s arms. (LPN G) then grabbed (R203)s arms and according to (CNA K) got into his face shouting You don't put your hands on me that is assault and a felony, and I will call the cops. (CNA K) then put his arm between (LPN G) and (R203) and asked (R203) to release (LPN G), he complied. (LPN G) left the room, (CNA K) stayed with (R203) until he was calm.</p> <p>Where and when did the alleged incident occur: 23:15 in (R203's room).</p> <p>Were there any witnesses: (CNA K and CNA L)</p> <p>Review of the Facility Reported Incident report revealed in part: Where and when did the alleged incident occur: 23:15 in room [ROOM NUMBER]-A .Were there any witnesses: CNA K and CNA L .Date and time Physician was notified: 11/27/2024 @ 0006 .Administrator and/or State agency notifications: Administrator (NHA) notified on 11/27/24 at 07:40 am.</p> <p>Review of the medical record revealed R203 was admitted to the facility on [DATE] with diagnoses that included: dementia, major depressive disorder, anxiety and muscle weakness. According to the Minimum Data Set (MDS) assessment dated [DATE], R203 scored 3/15 on the Brief Interview for Mental Status exam (which indicated severely impaired cognition).</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of the facilities policy titled Abuse Prohibition Policy updated 9/22, documented in part Staff members, volunteers, family members, and others shall immediately report incidents of abuse and suspected abuse .Allegations by anyone who becomes aware of verbal, physical, mental, sexual or emotional abuse and mistreatment, neglect, exploitation, involuntary seclusion or misappropriation of property must immediately report it to his/her Administrator .The staff will report any allegations of suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown source to the Administrator and DON immediately.</p> <p>During an interview via telephone, on 1/15/25 at 1:45 PM, CNA L reported that on the night of 11/26/24 around 11:15 PM, she heard and observed LPN G screaming at R203. She reported R203 had been found by CNA K to have had a bloody nose upon entering the bathroom where R203 was at the time. CNA L reported that LPN G was yelling at R203 to keep the gauze in place to help stop his bloody nose and if he needed that he would have to get shot up, which she explained referred to getting sedation medication so that they could tend to his bloody nose. After approximately an hour of assisting CNA K with managing R203's bloody nose CNA L reported leaving the residents room and later hearing LPN G say to R203 You don't put your hands on if you put your hands on me I will put my hands on you, that is assault, I will call the cops. When asked if she felt the tone and words rose to the level of verbal abuse CNA L said Yes, definitely. When quired if/when the allegation of abuse was reported CNA L reported that both her and CNA K reported it to the most superior nurse on duty that shift, LPN M, around 12:30 AM and 1 AM. CNA L was unaware if LPNM reported the allegation to NHA or DON. CNA L reported that in the morning of 11/27/24 her and CNA K stayed after their shift and the allegations were reported to DON around 7-8 AM and to NHA shortly after that.</p> <p>During an interview on 1/16/25 at 11:17 AM with DON and NHA, NHA reported that the expectation for reporting of suspected abuse is to immediately report it to the administrator as stated in their policy. DON reported that the CNA's that had alleged verbal abuse of R203 were not re-educated on abuse reporting or disciplined for a delay in reporting.</p> <p>A review of CNA Ks employee record revealed completion of abuse training on 11/6/24.</p> <p>Multiple attempts were made to contact CNA K throughout the survey and no return call was received prior to survey exit. Multiple attempts were made to contact LPN M, with no return call received prior to survey exit.</p> |   |  |