

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2025
NAME OF PROVIDER OR SUPPLIER  The Laurels of Coldwater		STREET ADDRESS, CITY, STATE, ZIP CODE  90 N Michigan Avenue 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0604  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.  (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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake 2604669 Based on observation, interview, and record review, the facility failed to ensure one resident (R1) of three reviewed was free from the use of a physical restraint. Findings include:Review of the facility reported incident revealed staff applied a sheet to [R1's] wheelchair (restraint) putting resident at risk for potential harm. Review of the medical record revealed R1 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included alcohol dependence with alcohol induced persisting dementia, pathological fracture of pelvis, wedge compression fracture of vertebra, and anxiety disorder. Review of the Brief Interview for Mental Status (BIMS-a cognitive screening tool) dated 8/22/25 revealed R1 scored 7 out of 15 indicating severe cognitive impairment. R1 sustained multiple falls while in the facility. On 8/29/25 at 9:52 AM, R1 was observed in bed with a staff member providing one on one supervision. In a telephone interview on 8/28/25 at 10:32 AM, Certified Nursing Assistant (CNA) E reported during the night shift on 8/18/25 into the morning of 8/19/25, they observed R1 halfway out of bed and had to assist R1 into their wheelchair and out to the nurses' station for supervision. CNA E reported around 2:00 AM, they heard Licensed Practical Nurse (LPN) H yell for help because R1 was close to falling out of their wheelchair. CNA E reported R1's body was slumped over with their head past their knees. CNA E reported it appeared R1 did not have any upper body control. CNA E reported they suggested supporting R1's upper body with a sheet to prevent R1 from slumping over. CNA E reported LPN H agreed so they proceeded to wrap a sheet around R1 with the ends of the sheet under R1's arms and then tied the sheet to the back handles of the wheelchair to prevent R1 from falling. CNA E reported at that time they did not think about the laws and rules that it's a restraint. In a telephone interview on 8/28/25 at 10:52 AM, CNA D reported during the night shift of 8/18/25 into the morning of 8/19/25, R1 was very agitated and wanted to get out of bed and into their wheelchair multiple times that night, which they assisted with doing. CNA D reported at one point; they came back to the nurses' station and R1 was sitting in their wheelchair while CNA E and LPN H were tying [R1] to the wheelchair with a bedsheet. CNA D stated, it was a restraint. She [R1] couldn't get out of it. CNA D reported they were not aware of how long R1 had the sheet tied around them but guessed approximately 15 minutes. In a telephone interview on 8/28/25 at 11:02 AM, (LPN) H reported R1 had just returned from the hospital after being one on one supervision in the hospital. LPN H reported R1 would not stay put no matter what they did with her. LPN H reported by 10:30 to 11:00 PM, R1 was exhausted and would not stay still. LPN H reported R1 was in the wheelchair with their head almost under the chair and hands on the floor. LPN H reported R1 did not have any core strength to hold herself up. LPN H reported CNA E suggesting using a sheet to assist with holding R1 in the chair. LPN H stated technically we aren't supposed to use a restraint, but they did not want R1 to fall. LPN H stated so I let [CNA E] put a sheet around [R1] and she tied it to the handles of the wheelchair. LPN H reported they got R1 sitting up enough, put a pillow in front of her and covered her with a blanket. LPN H reported R1 fell asleep after approximately 15 minutes and then was put back in bed. LPN H reported R1 was in bed all night after this until about 5:00 AM when it was discovered she fell in the doorway of her room. In an interview on 8/28/25 at 1:04 PM, Nursing Home Administrator (NHA) A reported R1 their investigation showed R1 was restrained to the wheelchair with a bedsheet on 8/19/25 at approximately 3:00 AM. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: R1 placed on one on one for observation, investigation, review of the Abuse Prohibition Policy, staff education on the Abuse Prohibition Policy with the focus on identifying a physical restraint and reporting, and audits pf staff knowledge of abuse policy, restraints, and reporting. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>		