

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 12/17/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect the resident's right to be free from verbal abuse by staff. Findings Included: This citation pertains to intake number 2622835. Per the facility Electronic Medical Record (EMR) Resident #3 (R3) was admitted to the facility on [DATE]. Diagnoses included post-traumatic stress disorder (PTSD), anxiety, and history of physical abuse. Review of a Minimum Data Set, dated [DATE] revealed R3 had a Brief Interview for Mental Status score of 15 out of 15 which indicated she R3 had no cognitive deficit. Review of a facility incident and investigation report revealed that on 9/5/2025 Certified Nurse Aid (CNA) D used abusive language towards R3 causing R3 emotional distress. The report revealed R3 overheard two CNA's, CNA C and CNA D talking, and she heard CNA C tell CNA D that R3 was faking her incontinence. R3 then turned on her call light and CNA D responded. R3 asked CNA D for a grievance form and CNA D told her that she did not need one. The report revealed R3 asked CNA D for her name and CNA D refused to tell R3 her name, and upon R3 persisting CNA D began to swear at her and raise her voice, then stated to R3 that she did not have to give R3 her F**king name. The report revealed that the facility found that verbal abuse occurred from CNA D towards R3, and CNA D was terminated from her employment at the facility. In an interview on 12/16/2025 at 1:28 PM, R3 stated that it was at the shift change when (CNA) C told CNA D, who was the oncoming CNA that she was incontinent and that she [NAME] being incontinent. R3 said she put on her CL, CNA D answered her call light, and she told CNA D that she does need help and was not faking it. R3 said she then went out to the hallway and got a grievance form to fill out for regarding CNA C making the comment that she faked being incontinent. R3 said when she was out in the hallway, she approached CNA D and asked her what her name was, and CNA D responded by saying that she did not have to tell me her F**king name was. R3 said that the Registered Nurse (RN) E took herself and CNA D into a conference room, and she tried to tell RN E what happened but said when she spoke CNA D kept saying I didn't do that b*tch. R3 said she would state to CNA D that it was her turn to talk, but CNA D would just say, no it is my turn b*tch. R3 said the only intervention RN E immediately did was tell CNA D to be quiet. In an interview on 12/16/2025 at 11:25 AM, RN E said R3 complained about CNA D not wanting to help change her from being incontinent. RN E said she took them R3 and CNA D into the conference room to see what happened. RN E said R3 was very upset. RN E said she called the manager on call, who was the Assistant Director of Nursing (ADON) F, and reported her that R3 was very upset, angry and did not want CNA D to care for her anymore. In an interview on 12/16/2025 at 12:18 PM, ADON F said CNA D had called her and told her what happened, but she got a different story. ADON F said R11, who is another resident, heard CNA D say to R3 that she did not give a sh*t about the form (grievance form), and that she was not going to give her F**king name to her. ADON F said both R3 and R11's statements of what CNA D said were the same. ADON F said R3 did fill out a grievance form and was upset that CNA D would not sign the grievance form. In an interview on 12/16/2025 at 1:55 PM, CNA D said her and CNA C were walking room to room giving report for shift change and said when they got the R3's room CNA C said R3 had fallen and was needing assistance. CNA D said R3 then put her call light on and said to her that she heard herself and CNA C said that she did not want to do anything for herself, and she wanted a grievance form. CNA D said R3 told her she was going to sign it. CNA D said she got R3 a grievance form. CNA D said RN F took herself and R3 into the conference room. CNA D said R3 went off. CNA D said she was never able to talk in the conference room, because R3 would not stop talking. CNA D said R3 did ask what her name was and said she just told R3 her name. In an interview on 12/16/2025 at 11:42 AM, CNA G said that R3 thought that when she had given CNA D report she had made a statement to CNA D that R3 was faking her incontinence. CNA G said R3 and CNA D got into an arguing match, and R3 was upset and angry. In an interview on 12/16/2025 at 1:46 PM, R11 stated that he heard CNA C say to CNA D that R3 was faking her incontinence. R11 said R3 wanted to fill out a grievance form and wanted to know CNA D's name but when she asked CNA D her name, CNA D said that she did not have to tell R3 her F**king name. Review of CNA D's education that the facility provided revealed that on 7/6/2025 CNA D received 0.75 hours of education on Abuse, Neglect, and Exploitation, and was graded a 100%. CNA D was also noted to have received education on the Elder Abuse: The Elder Justice Act Self-Paced on 9/1/2025 where she received 0.5 hours of educational time and was graded an 80%. Of note, CNA D received training in elder abuse on 9/1/2025 which was only four days prior to the verbal abuse and argument she was involved with regarding R3</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure care plans were reviewed and revised for four out of 11 residents (Resident #2, 6, 7, & 9). This citation pertains to intake numbers 2527031, 2669486, and 2656254. Resident #2 (R2): Per the facility electronic medical record (EMR) R2 was admitted to the facility on [DATE]. Record review of a facility incident report revealed that on 9/10/2025 R2 had an altercation with his roommate. R2 began to yell at his roommate to shut the mother f**king door to the bathroom because his roommate had turned the light on. The report revealed R2 yelled to his roommate to come over to him so he could slap him. Review of R2's progress notes dated 9/10/2025 revealed a notation that R2 threatened to physically harm his roommate because he had the bathroom door open. The note revealed R2's roommate growled at him then R2 began to get up, told him to shut the door, and he was going to beat him. The progress note revealed that the intervention was that R2 was moved to another room, which was a shared room. Review of R2's care plans revealed a care plan in place that stated (R2) has the potential for fluctuations in mood R/T (related to): unspecified psychosis, insomnia, major depression disorder with treatment in place., initiated on 2/17/2022, and last revised on 2/10/2025. Review of the interventions revealed none of the interventions were revised as a result of R2's aggression towards his roommate on 9/10/2025, nor were there any new interventions that identified and addressed R2's aggression towards other residents. The last revised intervention was dated 8/23/2023. No other care plan was found in R2's EMR that addressed his known aggression towards other residents nor interventions for prevention. R6 and R7: Review of a facility incident report dated 10/15/2025 revealed that about 6:30 AM R6 & R7 got into a disagreement because R6 turned on a light in the room, and then both residents made physical contact with each other. The incident report revealed R6 & 7 were heard by staff arguing and witnessed to have shove and swat at each other. The incident report revealed approximately 90 minutes after the light was turned on R7 confronted R6 by standing close to him and yelling. The report revealed R6 asked R7 to leave him alone and his stuff, but R7 then pushed R6, and then both residents began to strike each other with closed fists. R6 was moved to another room. Review of R6's care plans revealed a care plan that R6 had the potential for fluctuations in mood related to his diagnosis of depression, which was initiated on 6/16/2025 and last revised on 6/16/2025. Review of the care plan interventions revealed no interventions that address R6's aggression towards other residents after the incident. The last revised intervention was dated 5/18/2025. There were also no new interventions added to R6's plan of care post incident knowing aggression towards other resident occurred. No other care plan was noted to be on R6's EMR that address R6's aggression towards another resident with the potential for further aggression to occur, Review of R7's care plan revealed R6 was care planned for a potential for fluctuations in mood related to his diagnosis of dementia, depression, hallucinations, delusions. The care plan was initiated on 9/9/2024 with the last revision dated 9/10/2025. Review of the interventions revealed no interventions that addressed R7's aggression that occurred on 10/15/2025, no interventions were added to prevent further aggression towards other residents, and the last revised intervention was dated 3/25/2025. R9: Review of an incident report dated 10/30/2025 revealed R9 was found to be pushing his wife in her wheelchair, who was also a resident at the facility (R8), into their room and R9 attempted to use R8's arm and torso to turn the wheelchair when the wheelchair would not turn. The incident report revealed that a staff member heard R9 shouting at R8 and upon going in their room to assist the staff member saw R9 behind R8 yelling at her and grabbing her shoulder. R9 was heard by the staff member to call R8 an idiot. R8 was heard repeatedly to say to R9 to stop touching her, but then R9 struck R8 with an open hand in the shoulder/neck area and clutched R8's forearm. R8 was moved to another room. Review of R9's care plans revealed no care plan was put into place post incident for R9's aggression towards his wife R8, and no care plan was put into place for the fact that R9's wife was moved to another room, nor able to live in the same room as him for the time. In an interview on 12/17/2025 at 9:31 AM Director of Nursing (DON) B stated when an incident occurs, we have an Interdisciplinary Team (IDT) meeting to talk about the incident. DON B said the process for updating care plans was that during the IDT meeting the Social Worker had the computer up and would update care plans as the team discussed resident changes in their plan of care. DON B said that his expectation was, regarding the above incidents, that the resident's care plan be updated. DON B said he could not state why R2, 6, 7, & 9's care plan were not updated after each of the incident of aggression towards other residents, especially that the incidents were newly identified</p>		