

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 03/13/2026
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)
<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2690644. Based on observation, interview and record review, the facility failed to ensure a licensed medical provider (Physician, Nurse Practitioner, Physician Assistant) routinely examined pressure ulcers for one (R4) of three reviewed. Findings include: R4's medical record reflected they admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included osteomyelitis (infection in a bone) of vertebra, sacral and sacrococcygeal region and stage 4 pressure ulcers (wound that penetrates all three layers of skin, exposing muscles, tendons and bones) of the sacral region, right buttock and left buttock. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/3/26, reflected R4 scored nine out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was coded as having four stage 4 pressure ulcers. Two of the four pressure ulcers were coded as being present on admission/entry or reentry to the facility. On 3/12/26 at 11:52 AM, R4 was observed lying in bed, verbalizing ow and ouch. A specialty air mattress pump was hanging on the footboard of the bed. R4 stated they were doing terrible because of a bleeding tooth. On 3/13/26 at 1:22 PM, R4 was observed seated in a Broda chair, near a nursing station. A Physician Order, dated 10/6/26, reflected to cleanse R4's left ischium (lower/back part of hip bone) wound with wound cleanser, pat dry, pack the wound with a plain packing strip and cover with a bordered foam dressing, daily and as needed. An assessment of R4's left ischium stage four pressure ulcer, dated 3/11/26, reflected the wound had been present since admission [DATE], and wound progress was stalled/previously improving wound characteristics were plateaued. The wound measured 2.49 centimeters (cm) in length by 1.86 cm in width and one cm in depth. Undermining (tissue destruction extending under the skin edges, making the ulcer larger at the base than at skin surface) of 0.5 cm in length from 11:00 to 4:00 positions was documented. A Physician Order, dated 3/27/25, reflected to cleanse R4's right ischium wound with wound cleanser, pat dry, apply Dakins full strength moistened gauze to the wound and cover with a foam dressing, daily and as needed. An assessment of R4's right ischium stage four pressure ulcer, dated 3/11/26, reflected the wound was present on admission, and wound progress was improving. The wound measured 1.48 cm in length by 1.49 cm in width by 0.5 cm in depth. Undermining of one cm in length from 10:00 to 1:00 positions was documented. A Physician Order, dated 3/27/25, reflected to cleanse R4's sacrum (bone below the lumbar vertebrae/bones in lower spine) wound with wound cleanser, pat dry, apply Dakins full strength moistened gauze to the wound and cover with a foam dressing, daily and as needed. An assessment of R4's sacrum stage four pressure ulcer, dated 3/11/26, reflected the wound was facility-acquired on 11/17/23, and wound progress was improving. The wound measured 2.73 cm in length by 4.19 cm in width by 0.5 cm in depth. Undermining of 2.5 cm in length from 9:00 to 4:00 positions was documented. A Physician Order, dated 3/27/25, reflected to cleanse R4's left rear hip wound with wound cleanser, pat dry, apply Dakins full strength moistened gauze to the wound and cover with a foam dressing, daily and as needed. An assessment of R4's left rear hip stage four pressure ulcer, dated 3/11/26, reflected the wound was facility-acquired on 3/1/24, and wound progress was stalled/previously improving wound characteristics were plateaued. The wound measured 1.06 cm in length by 0.39 cm in width by 0.3 cm (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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>in depth. Tunneling (passageway of tissue destruction under the surface of the skin with an opening at skin level from the wound edge) of 4.5 cm in length at the 3:00 position was documented. In an interview on 3/12/26 at 2:37 PM, Licensed Practical Nurse (LPN) F reported being the facility's wound care nurse. LPN F reported R4 received hospice services, and wound treatments were directed by hospice. According to LPN F, R4's wound treatments were more directed towards comfort versus wound healing, and they were working towards keeping the wounds clean and free of infection. During the onsite survey, review of R4's Progress Notes from 5/1/25 to the most recent 3/12/26 at 12:19 PM did not reflect that a provider had examined R4's stage four pressure ulcers. On 3/13/26 at 11:00 AM, a verbal request was made to Nursing Home Administrator (NHA) A, for the most recent date that a provider had evaluated R4's pressure ulcers. A Physician Progress Note, dated 6/26/25 and provided by the facility, reflected R4 had a past medical history which included decubitus ulcers (pressure ulcers), was enrolled in hospice and continued to receive care for their sacral wound. The note reflected extensive sacral ulcerations were reported. The documentation did not reflect that R4's pressure ulcers were examined during the visit. In an interview on 3/13/26 at 1:40 PM, Director of Nursing (DON) B reported hospice conducted face-to-face evaluations, and the facility had meetings with hospice for care coordination. When asked if the provider would evaluate wounds during the face-to-face encounter, DON B reported that was the expectation. A hospice Nurse Practitioner (NP) face-to-face encounter, dated 2/28/26 and provided by the facility, reflected the presence of non-healing stage four pressure ulcers. Documentation did not reflect that R4's pressure ulcers were examined during the encounter.</p>		