

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/04/2026
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)		
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** This citation pertains to intake 3026546. Based on observation, interview and record review, the facility failed to report an allegation of resident-to-resident sexual abuse to the State Agency timely for two (R3 and R4) of three reviewed. Findings include: R3: Review of the medical record reflected R3 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included bilateral primary osteoarthritis of knee, anxiety, major depressive disorder ([DATE]) and suicidal ideations ([DATE]). The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R3 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and 11 out of 27 (moderate depression) on the Patient Health Questionnaire (PHQ-9/tool for screening and measuring depression severity). R4: Review of the medical record reflected R4 admitted to the facility on [DATE], with diagnoses that included vascular dementia and other sexual disorders ([DATE]). The admission MDS, with an ARD of [DATE], reflected R4 scored seven out of 15 (severe cognitive impairment) on the BIMS. R4 died in the facility on [DATE]. On [DATE] at 11:24 AM, R3 was observed lying in bed. R3 reported, on Monday, [DATE], around 4:20 AM, R4 entered his room and pulled her pants and brief down, fully exposing the lower half of her body. R3 alleged R4 grabbed his blanket and stated, just lay there, men don't know how to do it. R3 described that he attempted to use his reacher to push the emergency call button on the wall, but R4 had his reacher. R3 stated he pressed his call light and told R4 someone was going to come and see what she was doing. R3 reported R4 then pulled her pants up and exited the room. R3 stated R4 went to a room across the hall and got in an empty bed. Approximately 20 to 25 minutes later, staff responded. After taking R4 to her room, staff entered R3's room, and he explained what occurred. R3 stated he reported the incident to Licensed Practical Nurse (LPN) D around 6:00 AM the same day. R3 stated LPN D notified him she had to report the incident as sexual assault. R3 reported he sent an email to the Business Office Manager (BOM K) the same day ([DATE]), which included information about the incident. R3 stated Director of Nursing (DON) B came to speak with him about the incident shortly after he sent the email. In an interview on [DATE] at 1:20 PM, Nursing Home Administrator (NHA) A stated R3 reported a resident went into his room and started to take off her clothes. R3 said he understood the female resident was confused, that he was able to redirect her with his reacher, and she never touched him. NHA A said facility staff spoke to R3 right after the incident, and R3 reported he was not offended by it. NHA A indicated after R3 changed his story to a clear allegation of abuse (on [DATE]), the facility reported it to the State Agency. In a phone interview on [DATE] at 2:27 PM, Certified Nurse Aide (CNA) I reported R4 would enter the rooms of other residents at night. CNA I stated one night, R4 went into R3's room. CNA I could not recall if R4 said what she was doing in R3's room at the time. CNA I stated R4 made a comment that seemed sexual in nature. In a phone interview on [DATE] at 2:49 PM, CNA J reported R4 wandered on third shift, sometimes into other resident rooms to talk. CNA J described staff went looking for R4 (on [DATE]), as she was not in her room. CNA J reported R4 was observed in a bed, in another resident's room (across the hall from R3). CNA J stated when R3 and his roommate heard staff (redirecting R4), (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they reported R4 had been in their room, before going across the hall. CNA J stated R3 reported R4 said something sexually explicit and started taking her pants off, while in their room. CNA J stated they reported the incident to the nurse. In an interview on [DATE] at 9:02 AM, DON B reported being notified of the incident by BOM K and immediately going to speak with R3. R3 reported that R4 entered his room. DON B described that R3 told R4 no and to leave his room. R3 used his reacher to ward R4 off. According to DON B, R4 made a statement to R3 about men can't do something, and R3 got her to leave the room. DON B denied that R3 mentioned R4 removing any clothing or touching him in any way. DON B stated, when talking to R3, he did not mention anything about assault or being touched. DON B stated R3 was calm and not under duress, which was why the incident was not reported. DON B reported last week ([DATE]), R3 made statements that R4 touched him and pulled her pants down (on [DATE]). In an interview on [DATE] at 9:45 AM, LPN D reported while giving morning medications (on [DATE]), R3 said a confused woman took her pants off and got into bed with him. R3 told her she was in the wrong room and needed to leave, which she did. When clarifying if R3 stated R4 tried to get in bed with him, LPN D stated she was not sure if R4 attempted to get in bed with R3. LPN D reported asking R3 if he felt threatened, felt safe or sexually assaulted, and he said he was fine. LPN D stated she reported it immediately. On [DATE] at 10:49 AM, R3 was observed lying in bed. R3 reported, at the time, the interaction with R4 scared him. R3 perceived her comment to him as though she was going to have some type of sexual activity with him. In an interview on [DATE] at 11:12 AM, NHA A described that when speaking to R3 last week ([DATE]), R3 gave the same story as he had previously, except on [DATE], R3 used terminology that he was sexually assaulted. NHA A stated R3 never used that wording when DON B spoke with him (on [DATE]). NHA A indicated when R3 mentioned sexual assault, he reported the allegation to the State Agency.		

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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** This citation pertains to intake 3026546. Based on observation, interview and record review, the facility failed to investigate an allegation of resident-to-resident sexual abuse timely for two (R3 and R4) of three reviewed. Findings include: R3:Review of the medical record reflected R3 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included bilateral primary osteoarthritis of knee, anxiety, major depressive disorder ([DATE]) and suicidal ideations ([DATE]). The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R3 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and 11 out of 27 (moderate depression) on the Patient Health Questionnaire (PHQ-9/tool for screening and measuring depression severity).R4:Review of the medical record reflected R4 admitted to the facility on [DATE], with diagnoses that included vascular dementia and other sexual disorders ([DATE]). The admission MDS, with an ARD of [DATE], reflected R4 scored seven out of 15 (severe cognitive impairment) on the BIMS. R4 died in the facility on [DATE]. On [DATE] at 11:24 AM, R3 was observed lying in bed. R3 reported that on the Monday, [DATE], around 4:20 AM, R4 entered his room and pulled her pants and brief down, fully exposing the lower half of her body. R3 alleged that R4 grabbed his blanket and stated, just lay there, men don't know how to do it. R3 described that he attempted to use his reacher to push the emergency call button on the wall, but R4 had his reacher. R3 stated he pressed his call light and told R4 someone was going to come and see what she was doing. R3 reported R4 then pulled her pants up and exited the room. R3 stated R4 went to a room across the hall and got in an empty bed. Approximately 20 to 25 minutes later, staff responded. After taking R4 to her room, staff entered R3's room, and he explained what occurred. R3 stated he reported the incident to Licensed Practical Nurse (LPN) D around 6:00 AM the same day. R3 stated LPN D notified him that she had to report the incident as sexual assault. R3 reported he sent an email to the Business Office Manager (BOM K) the same day ([DATE]), which included information about the incident. R3 stated Director of Nursing (DON) B came to speak with him about the incident shortly after he sent the email. In an interview on [DATE] at 1:20 PM, Nursing Home Administrator (NHA) A stated R3 reported that a resident went into his room and started to take off her clothes. R3 said he understood the female resident was confused, that he was able to redirect her with his reacher, and she never touched him. NHA A said facility staff spoke to R3 right after the incident, and R3 reported he was not offended by it. NHA A indicated after R3 changed his story to a clear allegation of abuse (on [DATE]), the facility reported it to the State Agency. In a phone interview on [DATE] at 2:27 PM, Certified Nurse Aide (CNA) I reported R4 would enter the rooms of other residents at night. CNA I stated one night, R4 went into R3's room. CNA I could not recall if R4 said what she was doing in R3's room at the time. CNA I stated R4 made a comment that seemed sexual in nature. In a phone interview on [DATE] at 2:49 PM, CNA J reported R4 wandered on third shift, sometimes into other resident rooms to talk. CNA J described that staff went looking for R4 (on [DATE]), as she was not in her room. CNA J reported R4 was observed in a bed, in another resident's room (across the hall from R3). CNA J stated when R3 and his roommate heard staff (redirecting R4), they reported that R4 had been in their room, before going across the hall. CNA J stated R3 reported that R4 said something sexually explicit and started taking her pants off, while in their room. CNA J stated they reported the incident to the nurse, and that was the last she heard about it. In an interview on [DATE] at 9:02 AM, DON B reported being notified of the incident by BOM K and immediately going to speak with R3. R3 reported that R4 entered his room. DON B described that R3 told R4 no and to leave his room. R3 used his reacher to ward R4 off. According to DON B, R4 made a statement to R3 about men can't do something, and R3 got her to leave the room. DON B denied that R3 mentioned R4 removing any clothing or touching him in any way. DON B stated, when talking to R3, he did not mention anything about assault or being touched. DON B stated R3 was calm and not under duress, which was why the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident was not reported. DON B reported last week ([DATE]), R3 made statements that R4 touched him and pulled her pants down (on [DATE]). In an interview on [DATE] at 9:45 AM, LPN D reported while giving morning medications (on [DATE]), R3 said a confused woman took her pants off and got into bed with him. R3 told her she was in the wrong room and needed to leave, which she did. When clarifying if R3 stated R4 tried to get in bed with him, LPN D stated she was not sure if R4 attempted to get in bed with R3. LPN D reported asking R3 if he felt threatened, felt safe or sexually assaulted, and he said he was fine. LPN D stated she reported it immediately. On [DATE] at 10:49 AM, R3 was observed lying in bed. R3 reported, at the time, the interaction with R4 scared him. R3 perceived her comment to him as though she was going to have some type of sexual activity with him. In an interview on [DATE] at 11:12 AM, NHA A described that when speaking to R3 last week ([DATE]), R3 gave the same story as he had previously, except on [DATE], R3 used terminology that he was sexually assaulted. NHA A stated R3 never used that wording when DON B spoke with him (on [DATE]). NHA A indicated when R3 mentioned sexual assault, he reported the allegation to the State Agency and initiated an investigation. R3's medical record did not reflect documentation of the alleged incident from [DATE], until [DATE].		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3015141. Based on observation, interview and record review, the facility failed to revise the Care Plan for one (R2) of three reviewed. Findings include: Review of the medical record reflected R2 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included cerebral infarction (stroke) due to unspecified occlusion (blockage) or stenosis (narrowing) of the right middle cerebral artery, dysphagia (difficulty swallowing) following cerebral infarction, unspecified protein-calorie malnutrition (5/15/26) and gastrostomy (surgical opening through the abdomen, into the stomach) status (5/15/26). The Admission/5-day Medicare Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/4/26, reflected R2 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and received a mechanically altered diet. R2's medical record reflected they discharged to the hospital on 5/8/26. R2 readmitted to the facility on [DATE], with a feeding tube in place. On 6/2/26 at 9:40 AM, R2 was observed lying in bed, with their eyes closed. The head of the bed was slightly elevated. A tube feeding pump was observed at the left bedside, with tube feeding formula and a water flush hanging. On 6/3/26 at 8:47 AM, R2 was observed lying in bed, awake, with the head of the bed slightly elevated. Osmolite 1.5 Cal tube feeding formula and a water flush bag were hanging from a tube feeding pole at the bedside. The tube feeding pump was set for a tube feed infusion rate of 65 milliliters (mL) per hour. The water flush rate was set for an infusion of 250 mL every four hours. A Physician Order, dated 5/15/26, reflected, Nothing By Mouth diet Nothing By Mouth texture, Nothing By Mouth consistency. A Care Plan intervention, dated 5/1/26, reflected, Provide diet as ordered- Pureed [diet texture], nectar thick [liquid consistency]. An intervention, dated 5/1/26, reflected to assist the resident with meals as needed. An intervention, dated 5/6/26, reflected to provide diet as ordered, observe and document food acceptance and offer substitutes as needed. An intervention, dated 5/6/26, reflected to encourage fluid as tolerated. R2's Kardex (Certified Nurse Aide Care Guide) was noted to include the same interventions. In an interview on 6/4/26 at 9:02 AM, Director of Nursing (DON) B reported, at the time of readmission, it was the responsibility of the floor nurse to update the Care Plan. DON B reported the Interdisciplinary Team reviewed new orders and the hospital course upon readmission. At that time, they would also review the Care Plan. DON B acknowledged R2's Care Plan had not been revised and continued to reflect a pureed diet texture and nectar thick liquid consistency.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3026546. Based on observation, interview and record review, the facility failed to ensure timely mental and psychosocial evaluation or continued psychosocial support after a resident-to-resident sexual abuse allegation for one (R3) of three reviewed. Findings include: R3:Review of the medical record reflected R3 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included bilateral primary osteoarthritis of knee, anxiety, major depressive disorder (5/21/25) and suicidal ideations (8/8/25). The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/23/26, reflected R3 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and 11 out of 27 (moderate depression) on the Patient Health Questionnaire (PHQ-9/tool for screening and measuring depression severity).On 6/2/26 at 11:24 AM, R3 was observed lying in bed. R3 reported, on Monday, 4/13/26, around 4:20 AM, R4 entered his room and pulled her pants and brief down, fully exposing the lower half of her body. R3 alleged R4 grabbed his blanket and stated, just lay there, men don't know how to do it. R3 described, he attempted to use his reacher to push the emergency call button on the wall, but R4 had his reacher. R3 stated he pressed his call light and told R4 someone was going to come and see what she was doing. R3 reported R4 then pulled her pants up and exited the room. R3 stated R4 went to a room across the hall and got in an empty bed. Approximately 20 to 25 minutes later, staff responded. After taking R4 to her room, staff entered R3's room, and he explained what occurred. R3 reported he sent an email to the Business Office Manager (BOM K) the same day (4/13/26), which included information about the incident. R3 stated Director of Nursing (DON) B came to speak with him about the incident shortly after he sent the email. In an interview on 6/4/26 at 9:02 AM, DON B reported being notified of the incident by BOM K and immediately going to speak with R3. R3 reported that R4 entered his room. DON B described, R3 told R4 no and to leave his room. R3 used his reacher to ward R4 off. According to DON B, R4 made a statement to R3 about men can't do something, and R3 got her to leave the room. DON B denied R3 mentioned R4 removing any clothing or touching him in any way. DON B stated, when talking to R3, he did not mention anything about assault or being touched. DON B stated, R3 was calm and not under duress. DON B reported last week (5/27/26), R3 made statements that R4 touched him and pulled her pants down (on 4/13/26). In an interview on 6/4/26 at 9:45 AM, LPN D reported while giving morning medications (on 4/13/26), R3 said a confused woman took her pants off and got into bed with him. R3 told her she was in the wrong room and needed to leave, which she did. When clarifying if R3 stated R4 tried to get in bed with him, LPN D stated she was not sure if R4 attempted to get in bed with R3. LPN D reported asking R3 if he felt threatened, felt safe or sexually assaulted, and he said he was fine. On 6/4/26 at 10:49 AM, R3 was observed lying in bed. R3 reported, at the time, the interaction with R4 scared him. R3 perceived her comment to him as though she was going to have some type of sexual activity with him. In an interview on 6/2/26 at 2:07 PM, Social Worker (SW) C reported following up with R3 last week (5/27/26), after R3 reported he was sexually assaulted back in April. SW C reported R3 emailed the BOM about the incident at the time, but she had not been made aware of that (sexual in nature incident). SW C reported she had not followed up with R3 since 5/27/26. SW C acknowledged R3 had a history of depression and suicidal ideations. SW C reported she would typically follow up with a wellness check but could not speak to why she had not done that. R3's medical record did not reflect documentation regarding the alleged incident on 4/13/26, until 5/27/26.		