STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235302	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Coldwater,the	90 N Michigan Ave Coldwater, MI 49036

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on observation, interview, and record review, the facility failed to ensure a clean and homelike environment in eight out of 24 resident rooms, a resident lounge, and a resident TV/reading area resulting in un-cleanliness of resident living areas. Findings Included: During a tour on 8/20/2024 at 11:30 AM, R31's room was entered. It was noted that the floor next to bed B had three towels on the floor, and a strong foul smelling odor was noted. R31, who resided in bed B, stated that she had accidents (urinary incontinence) on the floor. R31 said housekeeping had already been in and cleaned her room, but did not pick up the towels or clean the floor. R31 stated she has the accidents frequently. On 8/21/2024 at 11:45 AM, R31's room was observed to have multiple flies, more than a dozen, in the room and several over R31's mattress. The mattress was observed to be stained from what R31 stated was urine and lymph fluid (a clear-yellowish fluid that can leak from the skin) drainage, an odor that was strong and not able to be identified was also noted. The odor also permeated the hallway. The floor next to the bed was noted to be excessively stained with dark matter, in which R 31 stated was urine and lymph fluid. R31 stated her room was not mopped daily. Cobwebs and dead insects in the cobwebs were observed in the window sill. The window blinds were observed to have insects and cobwebs all over the blinds from top to bottom. On 8/22/2024 at 8:10 AM, the odor remained in R31's. A saturated towel, mattress pad, and sheet was observed on the floor next to the bed, and a towel was observed in the wheelchair seat saturated in one area with unknown liquid. The floor remained stained. Flies, cobwebs and the window blinds remained the same as observed on 8/21/2024. In an interview on 8/22/2024 at 8:16 AM, Housekeeper (HKP) R stated she would clean R31's mattress, but stated it still had a bad odor and it was from urine. HKP R said the mattress would not come clean, and was saturated all the way through. HKP R stated that the floor by R31's bed was stained from urine and would not come up off the floor. HKP R said told Housekeeping Manager (HM) S about the floor, and said HM S told her to try her best to just mop it. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/22/2024 at 10:51 AM, Certified Nurse Aid (CNA) T stated that the odor from R31's room was contributed to R31's lymph drainage onto her bed, and incontinence of urine. CNA T said the mattress stains were from lymph drainage, and the floor stains were also from lymph drainage. CNAT stated that she had noticed flies in R31's room today CNA T also stated that the floor would not come clean, and said the mattress on R31's bed had not ever been replaced with a new mattress to the best of her knowledge, and that housekeeping would just clean it. During an observation on 8/20/2024 at 2:07 PM, the wall in room [ROOM NUMBER], at bed A, was observed to have paint rubbed off of the wall at the head of the bed, and a red color resembling blood was observed to be smeared on the wall at the side of bed A. On 8/21/2024 at 10:46 AM, room [ROOM NUMBER] was observed to still have the smeared blood on the wall at the side of bed A, and the paint peeled off remains at the HOB and side of the bed. On 8/20/2024 at 9:49 AM, the caulking around the toilet on the shared bathroom of room [ROOM NUMBER] was observed to be peeling away from the toilet and was black in color in several areas. On 8/21/2024 at 10:50 AM, the toilet hand rails, that residents used to lift themselves up from the toilet, were loose and moved side to side. In an observation on 8/22/2024 at 10:41 AM, room [ROOM NUMBER] bed A floor area was observed to have excessive sticky debris on the floor that the survey's shoes would stick to when walked over. The light fixtures for both bed A and B were observed to have multiple dead insects inside. Bed B was observed to have an air conditioner in the window that had an approximate 1/2-1 inch gap between the air conditioner and the side and bottom of the window frame. Flies were noted in the room, the telephone plug-in face plate was not fully attached to the and was hanging crooked, spider nests were observed in the lower corners of the bathroom, debris was noted on a ledge beside bed B, two ant traps were noted in the window sill. Resident in room [ROOM NUMBER] stated that little ants would come in the room, and said pest control would spray but the ants would just return. In an interview on 8/22/2024 at 12:14 PM, HM S stated that the odor in 31's room was from urine, and stated that a couple weeks ago she went into R31's room and did an inspected of the room, but did not document the inspection. HM S said no staff had told her about flies in the rooms. HM S was requested to provide the room deep cleaning schedule, but HM S stated she did not have a deep cleaning schedule for resident rooms. 30337 On 8/20/24 at 11:12 AM, Resident room [ROOM NUMBER] was observed with brown drips on the floor, chipped/loose paint on walls and around sink alcove. On 8/21/24 at 11:03 AM, the Lounge leading out to the courtyard was observed with a worn rug. Rust was observed on the door frame and the threshold had a gap under the door was observed with light coming in. The floor was raised in right corner of window attached to the door. Wallpaper was peeled off under window on the right side. Ceiling lights were heavily soiled with bugs. On 8/22/24 at 9:55 AM, the television/reading room leading to the courtyard was observed with a gap under the door missing most of the door sweep. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46954 On 8/20/24 at 9:17 AM, R21 was observed in her room seated in her wheelchair. R21 reported that her wheelchair was uncomfortable and despite reporting it to staff, nothing had been done. An observation of her wheelchair revealed that the vinyl on her arm rests the wheelchair were ripped and cracked, and the padding was exposed. On 08/20/24 at 12:21 PM, R86 was observed in his room, lying in bed. The wall adjacent to R86's bed was extremely dirty, smudged with debris in multiple areas. R86 had long facial hair covering his mouth, which was coated in food, and his shirt was extremely soiled from dropped food and beverage. R86's fingernails were long and caked with debris. The thermos R86 was attempting to transfer coffee into was extremely dirty and had gnats flying around it. R86's call light, bedside table, and television remote were visibly dirty. Several houseflies were present in the room and continuously landed on both myself and R86 during the observation and interview. R86's motorized wheelchair, observed in the room, was very dirty and covered in debris and grime. On 08/20/24 at 12:39 PM, Resident #38 was in bed watching television. The resident understood questions and was easily conversant. Resident #38 explained that he enjoyed getting up in his wheelchair and going outside. The resident presented with unkempt facial hair, long fingernails, and brown debris caked under several fingernails. When asked about the last time he had received a shower or bed bath, he was unsure. When asked about the last time he had received nail care, he was also unsure. When asked if he had refused grooming or nail care, Resident #38 stated he had not. His wheelchair, observed in the room, was very dirty. Houseflies and gnats were observed during the interview and were continuously landing on the resident. On 08/20/24 at 2:51 PM, R102 was observed in his room consuming lunch. R102 stated that he was unhappy with the lack of cleanliness in his room. R102's nightstand was cluttered with medical supplies, personal supplies, trash, and bowls of dry cereal. R102's bedside table surface was visibly grimy.

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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** 45038 Based on observation, interview, and record review the facility failed to report an allegation of abuse (bruise of unknown origin) to the State Agency for one Resident (#106) of two Residents reviewed for abuse. Findings Included: Resident #106 (R106) Review of the medical record revealed R106 was admitted to the facility 05/17/2024 with diagnoses that included cerebral vascular accident (stroke), atrial fibrillation, dysphagia (difficulty swallowing), Hemiplegia (paralysis) of the left side, hypertension, hyperlipidemia (high fat content in blood), depression, seizures, and cognitive communication deficit. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2024, revealed R106's Brief Interview of Mental Status (BIMS) was 00 (severe cognitive impairment) out of 15. During observation and attempted interview on 08/20/2024 at 10:28 a.m. R106 was observed lying in bed. R106 did not verbally respond to verbal questions. During a telephone interview on 08/20/2024 R106's family member C explained that R106 had received a black eye over her left eye while a resident at the facility. R106's family member C explained that she had identified R106's left black eye toward the end of June 2024 or July 2024. R106's family member C was informed that the black eye may have been caused by a medical device while the staff were providing care to R106. R106's family member C explained that she had report the black eye to the Director of Nursing but had not received any information as to what the definitive cause of the black eye or what corrective action was taken concerning the incident. Review of R106's medical record revealed a progress note dated 07/02/2024, which stated Resident observed with bruise to outer corner of left eye. Res. (Resident) denies any pain. Resident told her daughter that she's not sure how it happened, possibly bumped on bed [NAME] or corner of bedside table while staff turns/repositions. Pillow to be place on bedrail while turning/repositioning. Family in room and aware. R106's plan of care indicated the intervention Assist with ADLs (Activities of Daily Living)/Mobility/repositioning as needed. On 08/21/2024 at 01:01 p.m. requested Director of Nursing (DON) B to provide incident reports that would have been completed by the facility during R106's stay at the facility. In an interview on 08/21/2024 at 02:35 p.m. Nurse Manager (NM) J explained that she was the person who entered the progress note for R106 on 07/02/2024. When asked if an incident report was completed for the identification of R106's bruise, NM J explained that she had not and explained that she did not know if was necessary. NM J explained that she had talked with R106's husband and they had agreed that it could have happened when R106 rolled over in bed. NM J explained that she had not talked with one staff member who had told NM J that she never saw bruising to R106. NM J denied talking with any other staff members. (continued on next page)

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(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	In an interview on 08/21/2024 at 02:49 p.m. Director of Nursing (DON) B explained that no incident report had been completed during R106's stay at the facility. DON B explained that an incident report should have been completed for R106's bruise to her left eye but could not explain why an incident report had not been completed. DON B explained that an investigation was not completed for R106's bruise of unknown origin. DON B explained that a bruise of unknown origin should have been investigated and report to Nursing Home Administrator (NHA) A but did not know if it had been reported. In an interview on 08/21/2024 at 02:57 p.m. Nursing Home Administrator (NHA) A explained that a bruise of unknown origin should be reported as an allegation of abuse. NHA A explained that he was not aware of R106's bruise until today when he had been notified by Director of Nursing (DON) B. NHA A explained that an investigation had not been completed by the facility and an allegation of abuse had not been reported to the appropriate 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** 45038 Based on observation, interview, and record review the facility failed to investigate, implement preventive measures, and take corrective action for an allegation of abuse (bruise of unknown origin) for one Resident (#106) out of two Residents reviewed for abuse. Findings Included: Resident #106 (R106) Review of the medical record revealed R106 was admitted to the facility 05/17/2024 with diagnoses that included cerebral vascular accident (stroke), atrial fibrillation, dysphagia (difficulty swallowing), Hemiplegia (paralysis) of the left side, hypertension, hyperlipidemia (high fat content in blood), depression, seizures, and cognitive communication deficit. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2024, revealed R106's Brief Interview of Mental Status (BIMS) was 00 (severe cognitive impairment) out of 15. During observation and attempted interview on 08/20/2024 at 10:28 a.m. R106 was observed lying in bed. R106 did not verbally respond to verbal questions. During a telephone interview on 08/20/2024 R106's family member C explained that R106 had received a black eye over her left eye while a resident at the facility. R106's family member C explained that she had identified R106's left black eye toward the end of June 2024 or July 2024. R106's family member C was informed that the black eye may have been caused by a medical device while the staff were providing care to R106. R106's family member C explained that she had report the black eye to the Director of Nursing but had not received any information as to what the definitive cause of the black eye or what corrective action was taken concerning the incident. Review of R106's medical record revealed a progress note dated 07/02/2024, which stated Resident observed with bruise to outer corner of left eye. Res. (Resident) denies any pain. Resident told her daughter that she's not sure how it happened, possibly bumped on bed [NAME] or corner of bedside table while staff turns/repositions. Pillow to be place on bedrail while turning/repositioning. Family in room and aware. R106's plan of care indicated the intervention Assist with ADLs (Activities of Daily Living)/Mobility/repositioning as needed. On 08/21/2024 at 01:01 p.m. requested Director of Nursing (DON) B to provide incident reports that would have been completed by the facility during R106's stay at the facility. In an interview on 08/21/2024 at 02:35 p.m. Nurse Manager (NM) J explained that she was the person who entered the progress note for R106 on 07/02/2024. When asked if an incident report was completed for the identification of R106's bruise, NM J explained that she had not and explained that she did not know if was necessary. NM J explained that she had talked with R106's husband and they had agreed that it could have happened when R106 rolled over in bed. NM J explained that she had not talked with one staff member who had told NM J that she never saw bruising to R106. NM J denied talking with any other staff members. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/2024 at 02:49 p.m. Director of Nursing (DON) B explained that no incident report had been completed during R106's stay at the facility. DON B explained that an incident report should have been completed for R106's bruise to her left eye but could not explain why an incident report had not been completed. DON B explained that an investigation was not completed for R106's bruise of unknown origin. DON B explained that a bruise of unknown origin should have been investigated report to Nursing Home Administrator (NHA) A but did not know if it had been reported. In an interview on 08/21/2024 at 02:57 p.m. Nursing Home Administrator (NHA) A explained that a bruise of unknown origin should be reported as an allegation of abuse. NHA A explained that he was not aware of R106's bruise until today when he had been notified by Director of Nursing (DON) B. NHA A explained that an investigation had not been completed by the facility and an allegation of abuse had not been reported to the appropriate agency.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to develop and implement the care plan, in 1 of 26 residents reviewed for care plans (Resident #24) resulting in unmet needs. Findings include: Resident #24 (R24) Review of the electronic medical record reflected R24 was admitted to the facility on [DATE] with diagnoses that included acquired absence of left leg below the knee, history of falling, acquired absence of right leg below the knee, need for assistance with personal care, and cognitive communication deficit. The Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 7/22/24, reflected that R24 scored a 15 out of 15 on the Brief Interview for Mental Status (cognitively intact). On 08/20/24 at 11:59 AM, R24 was observed in bed. During an interview attempt, R24 reported that he could not hear me. Despite multiple attempts at getting closer to the resident and speaking very loudly, R24 stated that he still could not hear me well enough to answer questions. Nonverbal attempts were made to inquire about hearing aids and R24 stated that his hearing aides were in his closet in a brown oatmeal box. R24 activated his call light for assistance in gathering his hearing aids from staff. R24 was agreeable to wearing hearing aids. On 08/20/24 at 12:02 PM, staff entered the room and assisted in attempting to locate his hearing aids. LPN E stated that R24 does not wear hearing aids, however, staff members searched the room attempting to locate his hearing aids. Staff attempted to question R24 about the whereabouts of the hearing aids and R24 stated I can't hear anything! CNA F was assisting with attempting to locate the hearing aides and stated, I've never known him to have hearing aids. Review of R24's Care Plan revealed an impaired communication related to hearing deficit focus initiated on 6/19/23. Interventions included encourage resident to wear hearing aids. Ensure in place and functioning q (every) shift while awake as resident will allow. Ensure availability, functioning, and effectiveness of adaptive communication equipment hearing aids. Observe for confounding problems .hearing impairment (ear discharge and cerumen (wax) accumulation ect and report to physician and nurse as needed. On 8/20/24 at 2:37 PM, Director of Nursing B reported that R24 had hearing aids in his ear. In an interview ON 08/22/24 at 1:17 PM, Certified Nursing Assistant U reported that she is familiar with R24 and has never known him to have hearing aids. CNA U reported that staff looked for quite a while for his hearing aids on Tuesday and is unsure where they were located. CNA U stated that it is common practice to speak loudly directly into his ear for him to hear staff. On 8/20/24 at 4:11 PM, R24 was observed in bed. A hearing aid was visible in his left ear. Despite having the hearing aid, R24 stated that he still could not hear me and that the hearing aids don't work. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Audiology consult dated 2/22/24 revealed a hearing exam was requested by the facility for R24 for decreased hearing. The consult indicated that R24 had moderate to moderate severe hearing loss. The report stated R24 had two hearing aids that were working well. Review of an Ear Care Visit note dated 7/2/24 revealed R24 was seen for impacted cerumen. R24 presented with severe hearing loss and a reported history of ear wax issues. The same note indicated that R24 had impacted cerumen bilaterally. Cerumen is completely occluding. The assessment/plan section of the note stated unable to clear either ear obstruction at this visit. Recommend Debrox (an eardrop that softens and loosen ear wax, making it easier to remove) or other cerumen removal protocol .recommend bilat (bilateral) ear irrigation for cerumen removal by facility or provider. Review of R24's Physician Orders revealed no order for Debrox, or any other ear drop to assist with the removal of R24's impacted cerumen. Review of the Electronic Medical Record revealed no documentation that indicated that R24's primary care physician was notified of the impacted cerumen and/or any cerumen removal procedure was performed. In an interview on 08/22/24 at 2:12 PM, Registered Nurse (RN) T stated that she was unable to locate any Physician Order for the recommended ear drops. RN T stated that the expectation would have been to review the audiology note and implement the recommendations.

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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** 38383 Based on observation, interview and record review, the facility failed to revise the Care Plan for two (Resident #68 and #88) of 26 reviewed for Care Plans. Findings include: Resident #68 (R68): Review of the medical record reflected R68 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included dependence on renal dialysis. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/21/24, reflected R68 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 08/22/24 at 11:00 AM, R68 was observed seated in a wheelchair. A clear dressing, dated 8/19/24, was visible near her right chest. R68's Care Plan reflected she received hemodialysis (process to filter blood for people with kidney failure) and had a right internal jugular cuffed catheter (used for hemodialysis access). During an interview on 08/22/24 at 10:08 AM, Certified Nurse Aide (CNA) P reported R68 had a dialysis access site in her chest, and one was placed in her arm. CNA P reported she believed the dialysis access was in R68's left arm. CNA P described that blood pressures were to be taken on the arm without the dialysis access. When asked how staff were aware of care needs, including things to avoid pertaining to R68's dialysis graft, CNA P reported all residents had a Care Plan that could be accessed at any time. Staff could also ask the nurse if there were any questions. During an interview on 8/22/24 at 10:25 AM, LPN Q reported R68 no longer had a dialysis catheter in her chest/neck. LPN Q reported R68 had an implant that she believed was on her left side. R68's August 2024 Medication Administration Record (MAR) reflected an order for, Observe dialysis catheter for bleeding, infection, and catheter caps intact. every shift. As of 8/22/24 at 11:21 AM, LPN Q had signed the order out on eleven days, including 8/21/24 and 8/22/24. On 08/22/24 at 11:12 AM, LPN Q reported she confirmed that R68 still had a dialysis catheter to her right chest/neck. R68's medical record reflected Physician's Orders, dated 8/2/24, pertaining to dialysis graft care. The orders included no tight clothing or jewelry over the arm with the graft, no blood draws or blood pressure on the arm with the graft, not lying on the arm with the graft and to raise the affected area above heart level when sitting or lying. The orders did not indicate which arm R68's graft was located in. A Consultation Report, dated 8/12/24, reflected sutures were taken out of R68's left arm surgical site, and approval was given to use the access for dialysis treatments. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R68's Care Plan was not reflective of a dialysis graft in her left arm. 45038 Resident #88 (R88) Review of the medical record revealed R88 was originally admitted to the facility 03/14/2023. R88 was discharged from the facility 08/11/2024 and most recently readmitted , after a hospitalization , on 08/15/2024. R88 was readmitted with diagnoses that included pneumonia, vitamin D deficiency, liver disease, chronic respiratory failure, chronic hypercapnia (high carbon dioxide levels in blood), muscle weakness, multiple left sided rib fractures, dementia, anxiety, hypertension, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux, atrial fibrillation, history of falling, obstructive sleep apnea, emphysema, and hear failure. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/2024, revealed a Brief interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. During observation and interview on 08/20/2024 at 02:51 p.m. R88 was observed lying in bed. R88 explained that he recently had fallen and fractured several ribs on his left side. R88 explained that he was getting off the bus, that had taken him to the county fair and had missed the step while getting off the bus. R88 explained that after the fall it was necessary for him to go the hospital where he was diagnosed with pneumonia. Review of R88's medical record revealed a progress not from 08/08/2024 which stated, resident fell at approx. 4 p.m. when exiting (facility van) after LOA(leave of absence) to fair. He fell on the steps and landed on his L(left) side. ROM (range of motion), VS (vital signs), neuos were all WNL (with in normal limits). He did not hit his head .new orders for STAT (immediately) xray to L ribs. R88's medical record revealed acute left ninth rib fracture. Review of R88's medical record demonstrated that he was sent to the hospital on 08/11/2024 related to shortness of breath and decreased blood oxygenation levels. R88's medical record demonstrated that he returned to the facility 08/15/2024 with the diagnosis of pneumonia and continued antibiotics that were started at the hospital. Reivew of R88's plan of care demonstrated a problem statement, last updated 03/15/2023, which stated . is at has acute pain and risk for chronic pain related to compression fracture T1 and left clavicle fracture, GERD, BPH, subdural hemorrhage, and enlarged lymph nodes. R88's plan of care for pain did not include the recent fracture of left side ribs. Review of R 88's plan of care demonstrated a problem statement, last updated 03/31/2023, stated . has a potential for difficulty berthing and risk for respiratory complications R/T: COPD, emphysema, heart failure and obstruction sleep apnea. R88's plan of care did not include his recent diagnosis of pneumonia or any interventions that had been added since his return to the facility with the diagnoses of pneumonia. R88's plan of care did not demonstrate any information regarding his recent diagnosis of pneumonia. Review of R88's plan of care did not demonstrate his recent fall which resulted in left sided rib fracture. (continued on next page)

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Laurels of Coldwater,the	90 N Michigan Ave Coldwater, MI 49036

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/22/2024 at 09:21 a.m. Nurse Manger (NM) J explained that she was the Nuse Manager for the unit R88 resided. NM J explained that a Residents plan of care is to be updated by the staff nurses, the nurse managers, and the Minimum Data Set (MDS) nurses. NM J was asked if a Resident had a fall that resulted in fractures should that be included in the Residents plan of care and if a Resident had been diagnosed with pneumonia should that be include in the Residents plan of care. NM J explained that pneumonia diagnosis and a fracture diagnosis should be include in a Residents plan of care. NM J reviewed R88's plan of care and could not demonstrate that his recent rib fractures and pneumonia had been added to his plan of care. NM J could not explain why that information had not been care planned. In an interview on 08/22/2024 at 09:32 a.m. Minimum Data Set (MDS) nurse L explained that she was responsible to update a Residents plan of care when a Resident would be readmitted to the facility. MDS nurse L explained that she usually reviews the Residents hospital discharge summary to identify if items needed to be added to the Residents plan of care. In an interview on 08/22/2024 at 09:29 a.m. Director of Nursing (DON) B explained that Resident's plan of care is to be updated by the staff nurse, nurse managers, and the Minimum Data Set (MDS) nurses. DON B explained that residents plan of care should include accurate information regarding falls, fractures, pain, and infections. DON B reviewed R88's plan of care and could not demonstrated that it included R88's recent rib fractures, R88's recent hospital diagnoses of pneumonia, or R88's pain plan of care related to the rib fracture or pneumonia. DON B could not explain why R88's plan of care had not been accurately updated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to ensure that hygiene, grooming, and activities of daily living (ADL) needs were met for two of three residents reviewed (Residents #38 and #86). This resulted in the residents not receiving ADL care according to their individual preferences with the potential of feelings of shame or embarrassment and unmet care needs. Findings include: Resident #38 (R38) Review of the electronic medical record indicated that Resident #38 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right dominant side, aphasia (difficulty speaking or understanding others), and reduced mobility. The Kardex for Resident #38 revealed that the resident was dependent on one staff for bathing and grooming assistance. On 08/20/24 at 12:39 PM, Resident #38 was in bed watching television. The resident understood questions and was easily conversant. Resident #38 explained that he enjoyed getting up in his wheelchair and going outside. The resident presented with unkempt facial hair, long fingernails, and brown debris caked under several fingernails. When asked about the last time he had received a shower or bed bath, he was unsure. When asked about the last time he had received nail care, he was also unsure. When asked if he had refused grooming or nail care, Resident #38 stated he had not. His wheelchair, observed in the room, was very dirty. Houseflies and gnats were observed during the interview and were continuously landing on the resident. On 08/21/24 at 1:39 PM, Resident #38 appeared the same, with houseflies and gnats continuing to be present in the room. On 08/22/24 at 11:13 AM, Resident #38 appeared unchanged, and houseflies and gnats remained in the room. In an interview on 08/22/24 at 1:21 PM, Certified Nursing Assistant (CNA) U stated that Resident #38 is receptive to receiving showers but can be particular about which staff assist him. CNA U also noted that if a resident refuses a shower, a bed bath should be offered. Regardless of whether a resident accepts or refuses a shower, general grooming care, including nail care and shaving, should always be offered and provided. Review of the task records revealed that Resident #38 had refused all showers for the past thirty days. There was no consistent documentation explaining why the resident refused showers, whether he was reapproached for a shower, if nursing staff were notified of the refusal, or if he had received a bed bath instead. No documentation could be located regarding refusals of general grooming and hygiene for Resident #38. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/22/24 at 2:12 PM, Registered Nurse (RN) T stated that the expectation is to offer a shower or bed bath three times. If a resident refuses, nursing staff should be informed, and a note should be entered into the electronic medical record. RN T emphasized that standard grooming, such as offering shaving and nail care, should still be provided as needed. Resident #86 (R86) Review of the electronic medical record indicated that Resident #86 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, muscle weakness, and multiple sclerosis. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/19/24, reflected that R86 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. The Kardex for Resident #86 revealed that the resident required partial to moderate assistance from one staff member for bathing and grooming. On 08/20/24 at 12:21 PM, R86 was observed in his room, lying in bed. The wall adjacent to R86's bed was extremely dirty, smudged with debris in multiple areas. R86 had long facial hair covering his mouth, which was coated in food, and his shirt was extremely soiled from dropped food and beverage. R86's fingernails were long and caked with debris. The thermos R86 was attempting to transfer coffee into was extremely dirty and had gnats flying around it. R86's call light, bedside table, and television remote were visibly dirty. Several houseflies were present in the room and continuously landed on both myself and R86 during the observation and interview. When asked about R86's shower days, he replied that they were Mondays and Thursdays. When asked if he ever refused showers, R86 reported doing so very rarely. When asked if he is offered showers, he said it happens seldom. When asked if staff offered to assist with his facial hair, he replied that they did not. When asked about nail care, R86 mentioned that he used to have a pair of nail clippers, but they went missing a while ago, and since then, no one has offered assistance. R86 stated that he would really enjoy a shower and getting cleaned up, noting that he hasn't been feeling like himself lately and would appreciate being freshened up. R86's motorized wheelchair, observed in the room, was very dirty and covered in debris and grime. On 08/21/24 at 1:29 PM, R86 was observed in his room consuming lunch. Although he was wearing a different shirt, food from lunch had spilled and saturated the chest area of his shirt. Food had accumulated in his facial hair. Houseflies and gnats continued to be present in the room. On 08/22/24 at 10:44 AM, R86 was observed in bed wearing the same t-shirt as the previous day. An accumulation of food and liquid was present on his shirt. R86 denied receiving assistance with cleanup after meals, which was confirmed by the observation. Houseflies and gnats continued to be present in the room, landing and crawling on R86's face and the soiled areas of his clothing. Review of the Shower Task revealed that R86 was marked as refusing all offered showers for the past 30 days. Only one progress note was found in the electronic medical record indicating that a shower was refused in the past thirty days. In an interview on 08/22/24 at 2:12 PM, Registered Nurse (RN) T stated that the expectation is to offer a shower or bed bath three times. If a resident refuses, nursing staff should be informed, and a note should be entered into the electronic medical record. RN T emphasized that standard grooming, such as offering shaving and nail care, should still be provided as needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 Based on observation, interview, and record review the facility failed to ensure that two Residents (#24, #102) physician orders were followed and failed to provide an assessment/intervention for bowel constipation for one Resident (#27) out of 26 Residents reviewed for Quality of Care. Findings Included: Resident #27 (R27) Review of the medical record revealed R27 was most recently readmitted to the facility 08/13/2024 with diagnoses that included bipolar disorder, left knee pain, dysphagia (difficulty swallowing), insomnia, left femur fracture, type 2 diabetes, morbid obesity, low back pain, hypertension, hyperlipidemia (high fat content in blood), gastro-esophageal esophagitis, and schizophrenia. R27's most recent completed Minimum Data set (MDS), with an Assessment Reference Date (ARD) of 07/14/2024, revealed a Brief Interview of Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. During observation and interview on 08/20/2024 at 02:15 p.m. R27 was observed sitting up in her wheelchair, at her bedside. R27 explained that she had recently been discharged from the facility but that her family could not provide the necessary care she required, and she returned to the facility. R27 explained that she was constipated and had not had a bowel movement since she was readmitted to the facility. Review of R27's medical record revealed a POC (Plan of Care) history, which is used to document care that is provided to the resident, demonstrated that R27 had not had a recorded bowel movement since her date of re-admission of 08/13/2024. Reivew of R27's medication record demonstrated an order for Polyethylene Glycol 3350 oral power 17 GM (grams)/Scoop give one scoop one time day for constipation. No other medication was present for constipation at time of review. In an interview on 08/21/2024 at 02:24 p.m. Nurse Manager (NM) J explained that the facilities bowel program including monitoring residents for their bowel patterns. NM J explained that if a resident had not had a bowel movement in three days then the attending physician would be notified, and an appropriate order would be received to assist the resident in having a bowel movement. Nurse Manger (NM) J reviewed R27's bowel movement history and confirmed that R27 had not had a bowel movement since her admission on 08/13/2024. In an interview on 08/21/2024 at 02:44 p.m. Director of Nursing (DON) B explained that the facility monitors a residents bowel movement by the Point of Care (resident medical record system) (POC). DON B POC has a dashboard that will alert the staff after three days if the resident has not had a bowel movement and appropriate action to assist with bowel movements would be taken. DON B explained that it is professional standards that interventions are need for a resident if no bowel movement had not occurred after three days. DON B explained that the facility did not have a bowel protocol to assist residents with bowel movements. DON B reviewed R27's bowel movement history and confirmed R27 had not had a bowel movement since her re-admission on 08/13/2024 and that no action taken was evident in R27's medical record. DON B could not explain why action had not been taken to assist R27 to achieve a bowel movement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46954 Resident #24 (R24) Review of the electronic medical record reflected R24 was admitted to the facility on [DATE] diagnoses that included acquired absence of left leg below the knee, history of falling, acquired absence of right leg below the knee, need for assistance with personal care, and cognitive communication deficit. The Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 7/22/24, reflected that R24 scored a 15 out of 15 on the Brief Interview for Mental Status (cognitively intact). On 08/20/24 at 11:59 AM, R24 was observed in bed. During an interview attempt, R24 reported that he could not hear me. Despite multiple attempts at getting closer to the resident and speaking very loudly, R24 stated that he still could not hear me well enough to answer questions. Nonverbal attempts were made to inquire about hearing aids and R24 stated that his hearing aides were in his closet in a brown oatmeal box. R24 activated his call light for assistance in gathering his hearing aids from staff. R24 was agreeable to wearing hearing aids. On 08/20/24 at 12:02 PM, staff entered the room and assisted in attempting to locate his hearing aids. LPN E stated that R24 does not wear hearing aids, however, staff members searched the room attempting to locate his hearing aids. Staff attempted to question R24 about the whereabouts of the hearing aids and R24 stated I can't hear anything! CNA F was assisting with attempting to locate the hearing aides and stated, I've never known him to have hearing aids. Review of R24's Care Plan revealed an impaired communication related to hearing deficit focus initiated on 6/19/23. Interventions included encourage resident to wear hearing aids. Ensure in place and functioning q (every) shift while awake as resident will allow. Ensure availability, functioning, and effectiveness of adaptive communication equipment hearing aids. Observe for confounding problems .hearing impairment (ear discharge and cerumen (wax) accumulation ect and report to physician and nurse as needed. On 8/20/24 at 2:37 PM, Director of Nursing B reported that R24 had hearing aids in his ear. In an interview ON 08/22/24 at 1:17 PM, Certified Nursing Assistant U reported that she is familiar with R24 and has never known him to have hearing aids. CNA U reported that staff looked for quite a while for his hearing aids on Tuesday and is unsure where they were located. CNA U stated that it is common practice to speak loudly directly into his ear for him to hear staff. On 8/20/24 at 4:11 PM, R24 was observed in bed. A hearing aid was visible in his left ear. Despite having the hearing aid, R24 stated that he still could not hear me and that the hearing aids don't work. Review of an Audiology consult dated 2/22/24 revealed a hearing exam was requested by the facility for R24 for decreased hearing. The consult indicated that R24 had moderate to moderate severe hearing loss. The report stated R24 had two hearing aids that were working well. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Ear Care Visit note dated 7/2/24 revealed R24 was seen for impacted cerumen. R24 presented with severe hearing loss and a reported history of ear wax issues. The same note indicated that R24 had impacted cerumen bilaterally. Cerumen is completely occluding. The assessment/plan section of the note stated unable to clear either ear obstruction at this visit. Recommend Debrox (an eardrop that softens and loosen ear wax, making it easier to remove) or other cerumen removal protocol .recommend bilat (bilateral) ear irrigation for cerumen removal by facility or provider. Review of R24's Physician Orders revealed no order for Debrox, or any other ear drop to assist with the removal of R24's impacted cerumen. Review of the Electronic Medical Record revealed no documentation that indicated that R24's primary care physician was notified of the impacted cerumen and/or any cerumen removal procedure was performed. In an interview on 08/22/24 at 2:12 PM, Registered Nurse (RN) T stated that she was unable to locate any Physician Order for the recommended ear drops. RN T stated that the expectation would have been to review the audiology note and implement the recommendations. Resident #102 (R102) Review of the electronic medical record indicated that Resident #102 was admitted to the facility on [DATE] with diagnoses including paraplegia, major depressive disorder, and anxiety. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/5/24, reflected that R102 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. On 08/20/24 at 2:51 PM, R102 was observed in his room consuming lunch. R102 stated that he was irritated that he had no been receiving his testosterone injections as he should, and that nursing had not given him an explanation as to why he was not receiving his testosterone injections. R102 reported that he had brought it to the attention of the staff, however, there had not been a resolution. Review of the Physician Orders revealed that R102 was ordered to have Testosterone Cypionate Intramuscular Solution 100 MG/ML (Testosterone Cypionate) Inject 100 mg intramuscularly one time a day every 14 day(s) for Testosterone replacement. Review of the July Medication Administration Record revealed that on 7-13-24, R102 was marked as away from the facility with medications. The order was for a intramuscular injection and no proof that R102 took the medication with him outside of the facility and self-administered could be located. Review of the August Medical Administration Record revealed that R102 was not administered the Testosterone injection. No documentation as to why he was not given the medication could be located. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/22/24 at 2:41 PM, Registered Nurse (RN) T stated she was unsure of the away from facility with meds notes. RN T reported that R102 would often sign himself out of the facility and spent time in the parking lot, however, the medication should have been offered and administered upon return to the building. As to why the medication was not administered on 8-12-24, RN T was unsure why the testosterone was not administered and if the physician was notified of the missed medication. RN T stated that the expectation would be to notify the provider of the missed medication and also provide accurate documentation to reflect the missed medication. RN T stated that she had recently started education on this process for the nursing staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30337 Based on observation, interview, and record review, the facility failed to maintain clean equipment, resulting in the potential for an increased risk of foodborne illness, affecting all residents that consume food from the kitchen. Findings include: During an observation in the kitchen on 8/20/24 at 9:38 AM numerous fruit flies were observed near the handwashing sink and dishwasher. The A dining room kitchenette was observed on 8/21/24 at 10:38 AM. The floors were sticky, and brown liquid stains were noted on the countertop. The sink was soiled and had excessive hard water buildup on the faucet. The cupboards near the sink were soiled and sticky. Under the sink the bottom of the cupboard was warped and buckled from water damage. The portable steam table pans were observed with water and food debris in all three pans. The plate warmer was observed with food debris. Food trays were observed stored on a folding chair across from the steam table. Fruit flies were noted near the sink. The B dining room kitchenette was observed on 8/21/24 at 10:52 AM. The portable steam table pans were noted with water and food particles in the pans and the countertop was soiled with food debris. Food debris was noted on the plate warmer. The cupboards were sticky with food residue. Two scoops, a ladle and tongs were observed in a cupboard soiled with food debris. The cupboard under the sink was warped from water damage and soiled with spider webs and particles. A soiled towel was observed sitting on the countertop. Dietary Staff (DS) V was interviewed on 8/21/24 at 12:11 PM, in the A dining room kitchenette; and stated the water trays in the steam table were drained and cleaned once weekly, unless there was a spill. DS V confirmed the water in the steam table was the same as observed following breakfast. DS V stated the water in the steam table was last drained and cleaned on 8/20/24. Dietary Manager (DM) O was interviewed on 8/22/24 at 8:00 AM and stated pest control had been there that morning due to the fruit flies in the kitchen. DM O stated the steam tables should be drained and cleaned after each use and had started educating dietary staff. Hard water build up was noted on food covers and trays. DM O stated she had submitted a quote for a water softener. DM O stated trays were supposed to be brought back to the kitchen after meals and not stored on a folding chair. DM O stated soiled utensils should not be stored in the cupboard. A drawer in the main kitchen was observed with rice granules in a measuring cup, and food crumbs in the same drawer. The same drawer contained a spatula soiled with a brown substance. Multiple fruit flies were noted flying around all the sinks in the main kitchen. Heavy lime build-up was noted on the outside of the ice machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In review of the pest control report dated 8/22/24 from 5:24 AM to 6:43 AM, heavy fly activity in the fly lights and spiders throughout the building were observed. The same document included observations of flies in the kitchen and dining room with recommendation to remove spillage and food debris from the sink; and to clean and sanitize the sink and drains. The same document indicated it was the customers responsibility for completing recommendations. The same document indicated the facility had called for service on 8/21/24 and last had service on 8/08/24. DM O was interviewed on 8/22/24 at 11:44 AM and stated the pest control service recommended to clean the grease trap properly, clean the garbage disposal, and calking needed to be completed. DM O stated there were more flies in the kitchen this morning because the drains were disturbed. Registered Dietician (RD) W was interviewed on 8/22/24 at 12:48 PM and stated she usually was at the facility once or twice a week for clinical assessment and had not been asked to look at the kitchen. According to the 2017 FDA Food Code Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2017 FDA Food Code Section 6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12,7-206.12, and 7-206.13; Pf and (D) Eliminating harborage conditions.