STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235313	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Sandy Creek (the)	425 E Elm St Wayland, MI 49348

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. 41424 Based on observation, interview and record review, the facility failed to prevent involuntary seclusion in 1 of 6 residents (Resident #102) reviewed for abuse, resulting in the potential for a decline in physical, mental, and psychosocial well-being. Findings include: Review of an Admission Record revealed Resident #102 was a female with pertinent diagnoses which included spina bifida (birth defect in which the spinal cord fails to develop properly), chiari syndrome (brain tissue extends into the spinal canal), anxiety, depression, homicidal ideations, premenstrual dysphoric disorder (severe form of premenstrual symptoms that includes physical and behavioral symptoms), hydrocephalus (buildup of fluids in the cavities deep within the brain putting pressure on the brain and can cause brain damage), mood disorder, irritability and anger, seizures, mild intellectual disabilities, amputation of right lower leg, pain, and paralysis. Review of Care Plan for Resident #102 revised on 12/29/24, revealed the focus, .(Resident #102) has experienced trauma at some point during the past .TRAUMA: Childhood abuse/neglect, Sexual violence, and Other: Worried about court dates, life changes, guilt for family relationships, and change in living situation (LTC vs AFC home) .TRIGGERS: Other residents dying can trigger resident to have increased anxiety, an emotional outburst, agitation, fear, and unwanted thoughts . with the intervention .Establish and maintain a trusting relationship .Maintain a calm non-threatening relationship by listening to the resident/guest .Move slowly and avoid sudden movements .Personal triggers: Being alone with males, loud noises, and fear of dying .provide reassurance to the resident/guest that he/she is safe and the facility is doing what is needed to maintain safety for all .Encourage resident/guest to talk about past trauma, as needed .Encourage resident/guest to talk about past trauma as needed .Encourage resident/guest to be involved in activities and be engaged with others as possible and desired . (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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(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	Review of Nurses Note dated 1/26/25 at 2:59 PM, revealed, .Guest began to get frustrated with a dementia patient and started sighing. Writer informed staff and staff removed the dementia patient out of area. Another staff member attempted to take guest to her room and empty her catheter bag and she had an issue with that too, so staff member took her gloves off and walked away. Shortly after a guests family member came to facility and simply said hi to this guest and this guest replied, shut up. Staff member immediately attempted to put this guest into her room, and she started grabbing her door to not go into her room. Writer immediately went to help staff get guest into her room and guest began hitting, scratching and attempting to bite staff. Guest scratched guests neck and pulled name badge off writers shirt and broke holder to name badge. Writer has scratches on neck. Crisis center notified per orders and suggested guest get sent to (Local Hospital) for evaluation. Director of Nursing stated to have guest in facility at this time. Guest is in her room currently and staying calm at this time . In an interview on 2/4/25 at 3:14 PM, Certified Nursing Assistant (CNA) FF reported she had walked away from situation. CNA FF reported Resident #102 was originally at the nurse's station and followed her down the hallway towards the other unit. CNA FF reported we were in the hallway right outside of her room, another resident was with me as she was pushing her, bringing her to the other side of the building. CNA FF reported she asked Resident #102 if she could empty catheter bag really quick, she just huffs and puffs and acted frustrated, so she just stopped and continued on her way taking the other resident to the other unit. In an interview on 2/4/25 at 1:49 PM, Licensed Practical Nurse (LPN) Q reported she tried to take Resident #102 to her room after she was all huffy puffy. LPN Q reported when she (Resident #102) told the other resident's visitor to shut up, she (LPN Q) knew what was going to happen next, so she told the aide to get her and put her in her room. Resident #102 was fighting with the aide, so she went to help her, and she was yelling and attacking us, grabbed my shirt, trying to bite the CNA, she hit the CNA with a fist, and she was trying to grab her wheelchair wheels to get away from them. LPN Q reported this went on for approximately 5 minutes. Resident #102 bruised her breast, broke her name badge and scratched her neck. When queried if LPN Q attempted to redirect her, LPN Q responded can't do anything with her, and indicated she did not attempt to redirect her or remove herself from the situation. LPN Q reported when she gets like that you can't redirect her. This writer clarified the resident had huffed and puffed as she was agitated with another resident and had told a visitor to shut up and when queried whether LPN Q attempted to redirect her or to implement other interventions. LPN Q replied with no as she was going to escalate as that was how she was, and we had to get her into her room away from others. LPN Q reported the staff do not get training for her behaviors; we were told to not call 911 on her anymore as this would prevent her from going to an AFC (assisted living facility) home. LPN Q reported the staff do receive training in the (online learning program) but that was primarily for residents with dementia not for residents who have severe behavioral and mental health concerns. LPN Q reported the staff were not equipped to deal with a resident with her type of behaviors. In an interview on 2/4/25 at 09:44 AM, CNA V reported she had not received any behavioral health training except for the (online learning program). CNA V indicated someone from the police department came and spoke to the staff about calling 911 for issues with residents and when to call them. CNA V reported if she suspected abuse she would go to the nurse and let them know, and then go to the administrator. When queried on abuse, CNA V reported the facility had not completed training with the staff on how to perform a physical restraint on a resident who was striking out and reported they should not be physically restraining a resident as it was a violation of their rights. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/4/25 at 09:53 AM, CNA G reported they were educated on abuse and neglect, and they do not perform physical restraint and if a resident was placed in their room against their will that would be seclusion. In an interview on 2/4/25 at 9:54 AM, CNA S reported for the interventions the staff would implement with a resident she would refer to the care plan for interventions after they initially tried to redirect the resident. CNA S reported the information was all in the computer and that was where they would find the specific interventions for a resident. CNA S reported the staff had not received any additional training to address those who may be having a mental health crisis and how to deal with it, if they were to perform a physical restraint it should be at the direction of the nurse. Note: Both CNAs reported the facility had a lot of resident who were younger with mental health concerns, and they did not feel they had the education on how to deal with them. In an interview on 2/4/25 at 10:15 AM, Registered Nurse (RN) P reported the staff were educated yearly on abuse and neglect. RN P reported the staff received their education via the (online learning program) and at times they would receive additional training. RN P reported when a crisis situation would arise, we would implement the interventions in the care plan, and if necessary, would transfer the resident out to the hospital. RN P reported the staff had not been educated on the performance of physical restraint and the facility does not use it. RN P reported resident had rights and the staff were educated on what their rights were. Review of Abuse Training dated 2/4/25, revealed, 51 out of 84 staff member had not completed the education for abuse. Review of policy, Abuse Prohibition Policy revised 9/9/2022, revealed, .5. The facility supervisory staff will integrate into the supervisory process monitoring the behavior of staff members and guests/residents that are indicative of high stress levels that may lead to abuse/neglect or may escalate a continuum of aggression .

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 41424 This citation pertains to intake number MI00148293. Based on interview and record review, the facility failed to ensure staff had appropriate competencies and skills needed to provide care in a manner that supported their psychosocial wellness in 1 (Resident #102) of 6 residents reviewed for behavioral competency, resulting in inappropriate staff to resident interactions, inability of staff to appropriately address the psychological distress, unmet care needs, and resident not maintaining or achieving highest practical psycho-social well being. Findings include: Resident #102: Review of an Admission Record revealed Resident #102 was a female with pertinent diagnoses which included spina bifida (birth defect in which the spinal cord fails to develop properly), chiari syndrome (brain tissue extends into the spinal canal), anxiety, depression, homicidal ideations, premenstrual dysphoric disorder (severe form of premenstrual symptoms that includes physical and behavioral symptoms), hydrocephalus (build up of fluids in the cavities deep within the brain putting pressure on the brain and can cause brain damage), mood disorder, irritability and anger, seizures, mild intellectual disabilities, amputation of right lower leg, pain, and paralysis. Review of Care Plan revised on 1/2/25, revealed the focus, .(Resident #102) has the potential for fluctuations in mood R/T: Premenstrual dysphoric disorder, Depression, Mood disorder, Irritability and Anger, Mild Intellectual disabilities . with the intervention .Approach in a calm, quiet manner. Maintain appropriate body language during interactions such as maintaining eye contact and sitting in a relaxed position . Assist in developing or providing resident with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity and socialization . Assist the resident to identify strengths, positive coping skills and reinforce these. Encourage resident to express feelings and provide time to talk as needed .Encourage family visits .Encourage participation in activities of preference .Encourage participation in ADL's .Observe and report to SW and/or physician prn acute changes in mood or behavior; feelings or sadness; increased anxiety/agitation, depression, withdrawal/loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills; how resident interacts with others .Observe and report to SW/physician as needed risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone . (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of Incident Investigation dated 11/17/24, revealed, .Type of Incident: Allegation of Verbal Abuse . Staff reported LPN (Licensed Practical Nurse) (LPN HH) was heard saying to (Resident #102) get your ass in your room, I'm not dealing with this.Where did the alleged incident occur: on 11/18/24 at [NAME] nursing station .Were there any witnesses .Yes .(Certified Nursing Assistant (CNA) II) and (CNA JJ) .Details from the witness: (CNA II) indicated that she was on the [NAME] unit when she heard (LPN HH) LPN telling (Resident #102) to get your ass to your room, I'm not dealing with this. (CNA JJ) indicated that (LPN HH) LPN came into work around 10 PM and was questioning (Resident #102) on why she was up. (CNA JJ) felt (LPN HH) tone was nasty. (Resident #102) was telling (LPN HH) she was waiting for 2 people to put her to bed .(LPN HH) then said you can go to bed, you should have been in bed. As they were discussing this with each other, I walked away to help another resident .Interview with affected resident: (Resident #102) indicated to DON (Director of Nursing) that she doesn't like (LPN HH). (Resident #102) was asked if she felt (LPN HH09 was mean or rude to her. (Resident #102) stated I don't like her. I really don't like her or (CNA II). I tell them that too .Interview with alleged perpetrator: I told (Resident #102) just get back to your room, get out of my face, just go back to your room and they will get back to you .(LPN HH) admits she may have stated get your ass back to your room, get out of my face .Summary Report of Facilities Conclusion: Allegation of Verbal abuse was alleged by a CNA regarding conversation between a resident and a nurse. Resident was displeased with the nurse and CNA on during the night shift and refused assistance. Resident became behavioral with escalating yelling and screaming. Resident was instructed to go to her room as this is care planned for quiet place to calm down. Resident continued with behaviors for more than 30 minutes and was told to go back to her room. Other staff who overheard the comment felt like the nurse was rude. Nurse indicate she may have stated get your ass back to your room, get out of my face.substantiate poor customer service and lack of recognition of need to remove self from an escalating situation if resident is safe . Review of Written Statement from CNA JJ revealed, .(LPN HH) came in around 10 PM questioning (Resident #102) why she was up w/a (with a) nasty tone. (Resident #102) told her she was waiting for 2 people to put her to bed .LPN HH) then said you can go to bed you should've been in bed. when they started to argue w/ each other I walked away to help another resident . This writer attempted to contact CNA II to discuss incident was unable to reach her. In an interview on 2/4/25 at 10:15 AM, Registered Nurse (RN) P reported she was in the break room and CNA II was eating her lunch and was venting to me about what happened earlier with Resident #102 and LPN HH. RN P reported CNA II reported she was disturbed by the comments the nurse was making to Resident #102. RN P reported she verified with her that she herself witnessed what was said and she said, yes. RN P informed the CNA this warranted a call to our administrator. RN P reported when the CNA was talking this hit my radar and what was said to the resident was inappropriate and the administrator needed to be called. (continued on next page)

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	235313	A. Building B. Wing	02/05/2025

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of Nurses Note dated 1/26/25 at 2:59 PM, revealed, .Guest began to get frustrated with a dementia patient and started sighing. Writer informed staff and staff removed the dementia patient out of area. Another staff member attempted to take guest to her room and empty her catheter bag and she had an issue with that too, so staff member took her gloves off and walked away. Shortly after a guests family member came to facility and simply said hi to this guest and this guest replied, shut up. Staff member immediately attempted to put this guest into her room, and she started grabbing her door to not go into her room. Writer immediately went to help staff get guest into her room and guest began hitting, scratching and attempting to bite staff. Guest scratched guests neck and pulled name badge off writers shirt and broke holder to name badge. Writer has scratches on neck. Crisis center notified per orders and suggested guest get sent to (Local Hospital) for evaluation. Director of Nursing stated to have guest in facility at this time. Guest is in her room currently and staying calm at this time . In an interview on 2/4/25 at 3:14 PM, Certified Nursing Assistant (CNA) FF reported she had walked away from situation. CNA FF reported Resident #102 was originally at the nurse's station and followed her down the hallway towards the other unit. CNA FF reported we were in the hallway right outside of her room, another resident was with me as she was pushing her, bringing her to the other side of the building. CNA FF reported she asked Resident #102 if she could empty catheter bag really quick, she just huffs and puffs and acted frustrated, so she just stopped and continued on her way taking the other resident to the other unit. In an interview on 2/4/25 at 1:49 PM, Licensed Practical Nurse (LPN) Q reported she tried to take Resident #102 to her room after she was all huffy puffy. LPN Q reported when she (Resident #102) told the other resident's visitor to shut up, she (LPN Q) knew what was going to happen next, so she told the aide to get her and put her in her room. Resident #102 was fighting with the aide, so she went to help her, and she was yelling and attacking us, grabbed my shirt, trying to bite the CNA, she hit the CNA with a fist, and she was trying to grab her wheelchair wheels to get away from them. LPN Q reported this went on for approximately 5 minutes. Resident #102 bruised her breast, broke her name badge and scratched her neck. When queried if LPN Q attempted to redirect her, LPN Q responded can't do anything with her, and indicated she did not attempt to redirect her or remove herself from the situation. LPN Q reported when she gets like that you can't redirect her. This writer clarified the resident had huffed and puffed as she was agitated with another resident and had told a visitor to shut up and when queried whether LPN Q attempted to redirect her or to implement other interventions. LPN Q replied with no as she was going to escalate as that was how she was, and we had to get her into her room away from others. LPN Q reported the staff do not get training for her behaviors; we were told to not call 911 on her anymore as this would prevent her from going to an AFC (assisted living facility) home. LPN Q reported the staff do receive training in the (online learning program) but that was primarily for residents with dementia not for residents who have severe behavioral and mental health concerns. LPN Q reported the staff were not equipped to deal with a resident with her type of behaviors. In an interview on 2/4/25 at 09:53 AM, CNA G reported they were educated on abuse and neglect and they do not perform physical restraint and if a resident was placed in their room against their will that would be seclusion. In an interview on 2/4/25 at 9:53 AM, CNA H reported the training they received was specifically for residents with Dementia, Alzheimer's and PTSD. They had not received any training for residents who have schizophrenia and/or bipolar disorder. (continued on next page)

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	235313	A. Building B. Wing	02/05/2025

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F 0741 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/4/25 at 9:54 AM, CNA S reported for the interventions the staff would implement with a resident she would refer to the care plan for interventions after they initially tried to redirect the resident. CNA S reported the information was all in the computer and that was where they would find the specific interventions for a resident. CNA S reported the staff had not received any additional training to address those who may be having a mental health crisis and how to deal with it, if they were to perform a physical restraint it should be at the direction of the nurse. Note: All three CNAs reported the facility had a lot of resident who were younger with mental health concerns and they did not feel they had the education on how to deal with them. In an interview on 2/4/25 at 10:15 AM, Registered Nurse (RN) P reported the staff were educated yearly on abuse and neglect. RN P reported the staff received their education via the (online learning program) and at times they would receive additional training. RN P reported when a crisis situation would arise, we would implement the interventions in the care plan, and if necessary would transfer the resident out to the hospital. RN P reported the staff had not been educated on the performance of physical restraint and the facility does not use it. RN P reported resident had rights and the staff were educated on what their rights were. In an interview on 2/4/25 at 2:19 PM, Social Worker (SW) GG reported she does not work at the facility full time, she was filling in to help the facility out until they were able to hire a new social worker. SW GG reported she was unaware she was able to petition Resident #102 without guardian consent until last week. SW GG reported she would reach out the corporate social worker via emails since she was only working a few hours a week after hours and on the weekends. SW GG reported she had received education at the facility in regards to behavioral health education and had behavioral provider come to educate the staff on trauma informed care. SW GG reported the facility had more residents with behavioral health challenges now and the staff don't really get to know the residents and what triggers them and if the resident was set off, what works with each resident. SW GG reported if the staff don't understand and/or get to know the resident, they can set the residents off. In an interview on 2/5/25 at 8:36 AM, Activity Director (AD) BB reported she had been tracking the behaviors and held the behavioral health meetings. AD BB reported she had modified the behavior tracking for the CNAs as in the medical record they were not able to add additional information to the behavioral tracking. AD BB reported the behaviors for residents were documented on a sheet indicating what the behavior was, what intervention the staff tried and if it was successful. AD BB reported she does speak with the nursing staff to better understand the resident's behaviors, what behaviors changed, what's been documented in the record and she would also inform the staff of any behaviors they would need to monitor for when there were changes. AD BB reported they received education via the online training program. In an interview on 2/4/25 at 11:26 AM, Director of Nursing (DON) B reviewed Resident #102's medical record and when queried if the nursing staff had implemented person centered behavioral interventions on the resident's care plan when the incident occurred on 1/26/25 and DON B reported there were no documented attempted interventions in the record except moving her to a quiet place or her room. When queried if forcing Resident #102 into her room was part of her care plan, DON B reported it was not, they shouldn't have but she was care planned for removing her from the situation and have her go to a quiet place to calm down. When queried if the situation documented required the movement of Resident #102 to her room, DON B reported there was no way to know for sure what would happen next with Resident #102. DON B reported staff should have attempted to redirect her and implemented behavioral care interventions to address the situation. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/5/25 at 11:25 AM, Staff Development (SD) K reported the staff receive training monthly via the (online education program). SD K reported she monitored the completion of staff throughout the month and if they had not completed the trainings she would reach out to the supervisor, bring up during the morning meeting, and send out messages to try to get them to get it done. SD K reported she monitors staff implementation of behavioral training by watching and walking around, asks a lot of questions of staff, and if she was present during an incident she would provide one to one education to staff if it was needed. In an interview on 2/5/25 at 12:12 PM, Administrator A reported the staff had received multiple educations on de-escalation, trauma informed care, behavioral management, pain causing behaviors via a hospice presentation. Administrator A reported the facility had a population of residents who were younger and had more mental health concerns. Administrator A reported she walked the halls, does on the spot education with staff, received information from the behavioral management committee. Administrator A reported the staff had to realize the residents did not ask to be here, they were struggling with the age group and the behaviors, and she felt the staff allowed previous incidents influence/bias affect how they responded to a resident with behaviors. Administrator A reported she felt the facility was doing the best they could for all the people living at the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41027 Based on interview and record review, the facility failed to ensure an infection control surveillance plan was in place and included an ongoing collection and interpretation of data for 4 (Resident #109, #112, #113, and #114) of 15 residents with the potential to affect all 78 residents who reside at the facility, resulting in the potential for the spread of infection without timely identification and response, and the development and spread of infection to a vulnerable population. Findings include: In an interview on 2/4/25 at 4:45 PM, Infection Preventionist (IP) K reported that the facility used a computer based program for infection control surveillance, that populates with residents automatically when a infection assessment confirms infection. IP K reported that she did not have a list of residents that were currently on antibiotics, and that she was not sure if they were included in the computer program. IP K reported that based on the list, there were currently 8 residents in the facility with infections, but that she had not collected all of their information yet. IP K reported that there were no residents currently with UTI's (urinary tract infection), and there was 1 resident with a suspected UTI. This surveyor requested that IP K update the report with real time data for review. Review of the Infection Control Surveillance Monthly Report dated February 2025 indicated, Resident #114 had completed Cephalexin (antibiotic) treatment for a UTI on 2/3/25, and Resident #109 had completed Cephalexin treatment for a UTI on 2/3/25. Resident #112 and #113 were not included on the report. This report was received on 2/5/25 at approximately 8:00 AM. Resident #109 Resident #109's Physician Orders indicated that Cephalexin had been discontinued on 1/31/25, Cipro (antibiotic) was prescribed on 1/31/25 and then discontinued on 2/1/25, and Macrobid (antibiotic) was prescribed on 2/1/25. Resident #109's was currently receiving Macrobid, with an end date of 2/8/25. The infection control report was not an accurate reflection of Resident #109's status. Resident #112 Resident #112's Nurses Note dated 1/31/25 at 9:26 AM revealed, Resident urine dark and foul smelling this morning. Per NP (Nurse Practitioner), dip (in-house test) urine. Known bladder mass. Urine dip performed. Results: positive for blood, protein, leukocytes (white blood cells, indicative of infection) . Resident #112's Physician Orders revealed, Obtain urine and send to lab for UA (urinalysis urine test) w/ (with) C&S (culture and sensitivity) if indicated. This was ordered on 1/31/25. Resident #113 Resident #113's Physician Orders indicated that Bactrim (antibiotic) had been prescribed for UTI on 2/1/25 until 2/10/25. Resident #113 was currently receiving Bactrim. (continued on next page)

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	235313	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Sandy Creek (the)	425 E Elm St Wayland, MI 49348

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #114 Resident #114's Physician Orders indicated that Cephalexin had been prescribed on 1/29/25, with an end date of 2/8/25. Resident #114 was currently receiving Cephalexin. The infection control report was not an accurate reflection of Resident #114's status. In an interview on 2/5/25 at 8:53 AM, Director of Nursing (DON) B reported that infections and antibiotics are discussed every day in the morning meeting and should all have been included on the infection control surveillance report. DON B reported that Resident #112 and #113 should have been included on the report, and Resident #109 and #114 should not have been listed as resolved. In an interview on 2/5/25 at 1:30 PM, Nursing Home Administrator was notified that a past non-compliance for infection control would not be accepted due to current non-compliance.