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	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Sandy Creek	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2642001Based on interview, and record review, the facility failed to provide adequate supervision to prevent elopement and respond appropriately to an alarming exit door to ensure resident safety in 1 of 3 residents (Resident #101) reviewed for elopement/supervision, resulting in an Immediate Jeopardy when on 10/2/25 between 6:15 AM and 6:30 AM, Resident #101, who was an elopement risk, exited the facility, unbeknownst to facility staff, and was found by a Activities Director (AD) E approximately 50 yards away from the facility, in his wheelchair on the sidewalk of the road. This deficient practice placed all residents, identified as at risk for elopement, at risk for serious harm, injury, and/or death.Findings include:The facility failed to provide adequate supervision to prevent elopement for an exit seeking resident, Resident #101, who was an elopement risk, and respond appropriately to an alarming exit door to ensure resident safety. Resident #101 eloped from the facility unbeknownst to staff on 10/2/25 between 6:15 AM-6:30 AM was found by off duty staff at approximately 6:40 AM, 50 yards from the facility on the sidewalk of a 25 MPH (miles per hour) road, ambulating in his wheelchair. The Immediate Jeopardy began on 10/2/25 when Resident #101 eloped from the facility unbeknownst to staff. The Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on 10/21/25 at 10:20 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 10/2/25, and the deficient practice corrected on 10/7/25, prior to the start of the survey and was therefore past noncompliance.Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: severe depression with psychotic symptoms and anxiety. Review of Resident #101's Physician Orders indicated that a wanderguard (a wearable device that alerts staff when a resident is near an exit by activating the door alarm) was placed on his left ankle on 4/13/25. Review of Resident #101's Elopement Care Plan revealed, .at risk for elopement and/or wandering R/T (related to): history of attempts to leave facility unattended, impaired safety awareness. Date initiated 4/14/25 (no revisions). Interventions: Apply wanderguard per order. Check placement, function and expiration date per facility protocol. Wanderguard to LLE (left lower extremity) expires on 10/27 and wheelchair expires on 4/26. Date initiated: 4/14/25 Revision on 10/8/25, Approach in a slow, calm manner and redirect away from exit doors as needed. Date initiated: 4/14/25.Distract resident when wandering into inappropriate areas by offering pleasant diversions, structured activities, food, conversation etc.Date initiated: 4/14/25.Resident is to be 1:1 observation at all times for elopement risk and behaviors. Date initiated: 10/2/25.Review of Resident #101's Fall Care Plan revealed, .at risk for fall related injury and falls R/T: history of falling, psychotropic medication use, impaired balance, moderate cognitive impairment, impaired vision. Date initiated: 1/21/25. Revised 7/29/25.Review of Resident #101's Behavior Note dated 9/16/25 at 10:07 AM revealed, .Stated he has a meeting with case manager on 9/18 and case manager is going to help him Get out of here or I'm busting out. Either way alive or dead. Stating (hospital) sent him here to the warden because he couldn't get his pants off. Reports the warden put the ball and chain on my leg.Review of Resident #101's Progress Note dated 9/30/25 at 12:16 PM revealed, Resident observed alarming east exit door.Review of Resident #101's Elopement Incident Report dated 10/2/25 at 6:40 AM revealed, Alerted by activity director that resident was outside near the (facility) sign. Activity director remained with resident keeping him in sight. Resident in W/C (wheelchair). Approached and able to redirect back into building. Resident indicated he wanted to get some fresh air.CNA let two residents out front door by putting in door code. Once she opened the door for the residents she left the area. (Resident #101) tailgated out the door following behind residents. Alarm did not sound off because code was entered to open for the other residents. This report was noted to conflict with witness interviews and door alarm observations. In an interview on 10/20/25 at 4:23 PM, Certified Nursing Assistant (CNA) M reported that she had been working on the hall on 10/2/25 and heard a door alarming in the dining room between 6:10 AM-6:30 AM. CNA M reported that she observed two residents that wore wanderguards in the area at the time but was not sure why the door was alarming. Resident #101 was near the door and the other resident was being assisted by Physical Therapy Assistant (PTA) H. CNA M reported that she peeked out the door, then deactivated the door alarm and went back to the hall. CNA M reported that Resident #101 had anger problems but seemed calm that morning. CNA M reported that minutes later the door was alarming again and Resident #101's whereabouts were unknown; CNA M assumed the resident was in his room. CNA M looked out the dining room windows and when she did not see anyone