STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER The Laurels of Sandy Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2704281 and 2790806.Based on interview and record review, the facility failed to protect the residents' right to be free from verbal abuse and/or physical abuse by staff for 2 (Residents #107 and 104) of 3 residents reviewed for abuse resulting in feelings of sadness and/or being handled in an undesirable way.Findings include:Resident #107: Review of Resident #107's Incident report (Facility Reported Incident; submitted to the state survey agency by the facility), dated 11/28/25, noted that Resident #107 had a brief interview for mental status (BIMS) score of 13 (which reflected he was cognitively intact), Cognitive Status: Independent, PERPETRATORS.Registered Nurse (RN) BB, Date/Time Incident Occurred: 11/27/2025 01:00 am, and Incident Summary: Resident, (Resident #107) reported.[physical descriptors of staff omitted] nurse (RN BB), told him (Curse word censored for report; F***) you, I hate you and gave him the middle finger. Roommate (Resident #114) heard the interaction.facility will suspend staff member (RN BB). Review of Resident #107's Facility Reported Incident form, dated 12/2/25, stated, .Date of Incident: 11/27/2025.Type of Incident: Allegation of Verbal Abuse.What allegedly occurred: Resident (Resident #107) reported (RN BB) told him, f*** you, I hate you. Stating he was frustrated with him about his oxygen.Who is the alleged perpetrator? .6p-6a (6PM-6AM) night shift Staff, (RN BB). Were there any witnesses: Yes.Resident: (Resident #114).Resident (Resident #107) stated it occurred 11/27 (2025) between 1-4am.Details from the witness: Resident (Resident #107) shares a room with another resident, (Resident #114) (BIM's (sic) of 13), Resident (Resident #114) was asked if he had heard anything transpire on the evening in question. (Resident #114) reported he heard his roommate (Resident #107) and the male nurse (RN BB) arguing. He stated he heard the nurse (RN BB) use a cuss word and tell him, I hate you. (RN BB) stated that he spoke sternly with (Resident #107).Based on the Resident (Resident #107) with the allegation and confirmation from his roommate (Resident #114) we determine that verbal abuse occurred from (RN BB). Review of the facility's complaint form submitted to the State's professional licensing intake section, undated, stated, Resident (Resident #107) alleged that Nurse (RN BB) told him, F*** you, I hate you. Another resident (Resident #114) confirmed allegation. Nurse (RN BB) terminated for verbal abuse. During an interview on 3/24/26 at 12:30 PM, Resident #107 was seated on his bed in his room and reported he had an incident with (RN BB) on a night shift at the end of November 2025 (11/26/27-11/27/25) where (RN BB) told him that he didn't need oxygen, told him F*** you, I hate you, and gave him the middle finger. Resident #107 stated the comments (RN BB) made to him that night upset me and it really bothered me a lot. Resident #107 reported that had been the first time (RN BB) had said f*** you to him but said there had been times prior that (RN BB) told him that he didn't like him. Resident #107 stated, What did I do to have him say that to me? What did I do to him? I never (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did anything to him for him to hate me. Resident #107 confirmed he first notified the facility about (RN BB) on 11/28/25 and had not on any day prior. During an interview on 3/24/26 at 12:40 PM, Resident #114 recalled the incident between Resident #107 and (RN BB) from the end of November 2025. Resident #114 reported the curtain was pulled halfway so he could only hear the two speaking but reported he remembered hearing (RN BB) say to Resident #114 I hate you, f*** (curse word) you, and what are you going to do about it?. Resident #114 reported this incident occurred some time ago but reported he remembered it well. Resident #114 reported (RN BB) had been verbally aggressive towards Resident #107 several times prior to the 11/26/25-11/27/25 incident but couldn't remember exact details or dates. During an interview on 3/24/26 at 12:57 PM, Licensed Practical Nurse T confirmed RN BB no longer worked at the facility and thought Residents #107 and #114 had the cognitive ability to be able to report an incident such as the one alleged between Resident #107 and RN BB. During an interview on 3/24/26 at 3:36 PM, Nursing Home Administrator (NHA) A reported both Residents #107 and #114's cognitive statuses indicated they should be accurate historians and were considered believable sources regarding their verbal abuse allegations reported on 11/28/25 against RN BB. During an interview on 3/25/26 at 11:07 AM, Social Worker (SW) F reported Resident #107 hadn't made any other allegations against staff for being verbally or physically abusive that she was aware of. SW F stated if something was happening Resident #107 would make it known. SW F reported Resident #114 didn't have a history of making false allegations against staff that she was aware of. Resident #104 Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic pain, anxiety and dementia (a decline in mental ability in memory, reasoning, and communication). Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 1/23/26 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #9 was moderately cognitively impaired. Review of Resident #104's Care Plan revealed, Focus:(Resident #104) has potential for impaired communication r/t (related to) Hx (history) of CVA (cerebrovascular accident-stroke), cognitive impairment with dementia diagnosis. Date initiated: 5/8/24. Interventions: Use communication techniques to enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Turn off TV/radio as needed to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communicationtools as needed, such as communication book/board, writing pad, gestures, signs, and pictures. Date initiated:5/8/24 .Focus: (Resident #104) has the potential to demonstrate verbal aggression r/t anger, dementia, depression, mental illness, poor impulse control. Date initiated:7/19/24. Interventions: COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated . Date initiated: 8/13/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility reported incident (FRI) investigation summary revealed, . Date of event: Resident #104 was exhibiting agitation and increased pacing. Licensed Practical Nurse (LPN) CC requested Resident #104 go to her room and stay there as heard by witness. Resident #104 refused to go to her room. Resident #104 approached LPN CC attempting to strike her. LPN CC placed Resident #104's arms behind her back and physically assisted her to her room and closed the door. Resident #104 vocalized stop that hurts . In depth analysis of how deficiency occurred: LPN CC was not using skills of de-escalation. Her frustration perpetuated the situation to intensify, resulting in verbal and physical abuse to the resident . During an interview on 3/24/26 at 2:14 PM, LPN CC reported when she arrived to work her shift on 2/4/26 at 7:00 PM, that Resident #104 was already doing her pacing up and down the hallway like she always does and that Resident #104 was being aggressive towards other residents. LPN CC reported she started her medication pass when she noticed that Resident #104 was bothering the other nurse working at the facility. LPN CC reported LPN M asked her to come get Resident #104, so she went to the medication cart that LPN M and Resident #104 were standing at and asked Resident #104 to give LPN M some space. LPN CC reported in the past, Resident #104 had become triggered when asked to give space and since she knew that she politely put her hand on Resident #104's shoulder, but as she touched Resident #104's shoulder, she (Resident #104) turned around and started swinging on her. LPN CC reported she then got behind Resident #104 and guided (Resident #104) to her room with her hands around Resident #104's arms. LPN CC reported Resident #104 went into her room, and she told her to have a seat and stay in here for a minute. LPN CC reported Resident #104 was still pacing around her room and saying that she was going to leave. LPN CC reported Resident #104 went into her room on her own, but when she closed her room door, Resident #104 opened her door and came right back out. LPN CC reported she never yelled at Resident #104 and stated that she just had a loud voice. During an interview on 3/25/26 at 8:30 AM, Former CNA GG reported she had been working with LPN CC and LPN M on 2/4/26 and witnessed the physical interaction between LPN CC and Resident #104. Former CNA GG reported she had noticed earlier in the night that LPN CC had been a bit rude to Resident #104 when she was pacing the hallways and talking to other residents and staff. Former CNA GG reported she observed LPN CC go over to LPN M and Resident #104 and tell Resident #104 that she needed to leave LPN M alone and that she (Resident #104) was bothering her. Former CNA GG reported Resident #104 did not want to go to her room and told LPN CC that she was not going to go to her room which seemed to cause LPN CC to escalate. Former CNA GG reported she observed LPN CC grab both of Resident #104's wrists and placed them together behind her back and held Resident #104's arms up behind her back as she attempted to walk Resident #104 from the center hall area to her room. Former CNA GG reported that the position that LPN CC had placed Resident #104's arms in looked painful and Resident #104 was yelling ouch, that hurts and get off of me multiple times as she attempted to break free from the hold that LPN CC had her in. Former CNA GG reported that as LPN CC was continuing to take Resident #104 towards her room, she bashed Resident #104 into a utility closet. Former CNA GG reported that she was not sure if LPN CC intentionally bashed Resident #104 into the closet, or if it was because Resident #104 was trying to break free from LPN CC and LPN CC had to grab her even harder. Former CNA GG reported after LPN CC bashed Resident #104 into the utility closet, she continued to walk Resident #104 to her room, with her hands held behind her back, and Resident #104 continued to yell out that LPN CC was hurting her. Former CNA GG reported that she then watched LPN CC take Resident #104 into her room where she bashed her into the entrance area before entering Resident #104's room with her and slamming the door behind her. Former CNA GG reported that she could hear bashing around Resident #104's room and could hear Resident #104 screaming out Stop, I can't breathe. Former CNA GG reported that LPN CC opened (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #104's door shortly after and walked out and slammed the door on Resident #104. Former CNA GG reported Resident #104 opened the door twice and tried to exit her room, and both times LPN CC slammed the door on her and screamed at her to stay in her room. Former CNA GG reported that after she slammed Resident #104's door on her the second time, LPN CC walked away and entered another resident room, and she went to get Resident #104. CNA GG reported Resident #104 was visibly shaken, crying, and her hair was messed up as if it had been pulled. Former CNA GG reported that Resident #104 told her that LPN CC choked her and threw her to the ground. Former CNA GG reported she felt like something had happened when LPN CC was in the room alone with Resident #104 because of all the bashing she heard. Former CNA GG reported that she had instructed Resident#104 to go to the dining room and stay with the receptionist as another staff member was reaching out to report the incident to Nursing Home Administrator (NHA) A. Former CNA GG reported that she did not intervene when LPN CC went after Resident #104 because was terrified for her own safety. Former CNA GG reported Resident #104 had behaviors, but she was typically very easy to redirect. Former CNA GG reported that as long Resident #104 was approached nicely, she would typically have a positive response and could be de-escalated pretty easily. During an interview on 3/25/26 at 9:11 AM, LPN M reported she had been working in the evening on 2/4/26 and had noticed that Resident #104 was pacing back and forth as she normally did. LPN M reported Resident #104 then approached her and was talking to her as she prepared medications at her medication cart. LPN M reported it was common for Resident #104 to stand by her as she prepared medications, and that Resident #104 liked to stand and chat, and it seemed to help calm her anxiety. LPN M reported Resident #104 was not being disruptive when LPN CC approached her and told Resident #104 the nurse doesn't want you bothering her, which LPN M reported that she did not say. LPN M reported that Resident #104 laughed at LPN CC and that seemed to escalate LPN CC and she then told Resident #104, I am being serious as she was getting louder in tone. LPN M reported Resident #104 told LPN CC that she was not going to go to her room and LPN CC then told her yes you are which triggered Resident #104 and she attempted to strike LPN CC who then grabbed Resident #104's arms and whipped them behind her back LPN CC then grabbed Resident#104 and began to walk Resident #104 to her room. LPN M reported that Resident #104 was yelling out that LPN CC was hurting her and she was trying to break free from LPN CC when LPN CC picked up Resident #104 and slammed her into the utility closet door. LPN M reported LPN CC then took Resident #104 around the corner towards her room and she could not see them at first so she thought that LPN CC had let Resident #104 go, but then she heard the loud bashing noises from Resident #104's room and Resident #104 yelling out that so she went towards the room and was told by Former CNA GG that LPN CC had taken Resident #104 into her room and slammed the door. LPN CC reported she instructed Former CNA GG to call NHA A immediately, as she observed LPN CC exit Resident #104's room and slam the door on her. LPN M reported Resident #104 attempted to exit her room twice and both times LPN CC slammed the door on her and yelled at her to stay in her room. LPN M reported that LPN CC then walked towards another resident room and stated, I am not dealing with this lady (Resident #104), I will fight her. LPN CC reported that she was shocked to see LPN CC act so aggressive and she was too scared to get in between her and Resident #104. LPN M reported she felt like LPN CC was watching her and Former CNA GG after the incident and she was scared that she was going to escalate again and go after her or another resident. LPN M reported that although Resident #104 had a history of behaviors, she was very easy to redirect. During an interview on 3/25/26 at 11:59 AM, Receptionist O reported that she had been working on 2/4/26 when Resident #104 came into the dining room speed walking, crying and saying that she had just gotten into a fight. Receptionist O reported that she thought that Resident #104 was possibly confused, so she offered to take Resident #104 to her room because she thought she might be getting (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overstimulated. Receptionist O reported that when she offered to take Resident #104 to her room, and they began walking when Resident #104 began to freak out and that she told her that she did not want to go down there (the hallway where LPN CC was) because she did not want to get into another fight. Receptionist O reported that as Resident #104 was crying in the hallway and saying she did not want to go to the hallway her room was on, a staff member walked by and told her that What Resident #104 is saying is true and that she needed to keep Resident #104 away from that area. Receptionist O reported that Resident #104's hair was messed up, and she seemed very shaken. Receptionist O reported that Resident #104 had told her that LPN CC had grabbed her by her shirt and threw her down. During an interview on 3/25/26 at 9:32 AM, Resident #104 reported that she did recall the incident with LPN CC on 2/24/26, but Resident #104 did not want to talk about the incident with this writer. Resident #104 reported, I am just glad she (LPN CC) is gone, and that is all that mattered. During an interview on 3/24/26 at 1:25 PM, Nursing Home Administrator (NHA) A reported that she had substantiated that LPN CC had verbally and physically abused Resident #104 on 2/4/256 based on witness interviews. NHA A reported that she terminated LPN CC on 2/16/26. Review of the facility's Abuse policy last revised 9/9/22 revealed, Policy: Each Guest shall be free from abuse . To assure guest/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guest/residents . The facility was granted a Past Non-Compliance at the time of exit due to no further like incidents had occurred, the facility re-trained all facility staff on abuse, police were notified on 2/4/26, LPN CC was terminated from the facility, Resident #104's care plan was reviewed and updated on 2/5/26, Social Services monitored Resident #104 for emotional concerns and potential psychosocial decline related to the incident, (Local Mental Health Provider) was consulted and collaborated with facility provider on behavior interventions and medication changes for Resident #104, All residents with a Brief Interview for Mental Status (BIMS) score of 10 or higher were interviewed to ensure there were no further complaints, and the facility conducted weekly abuse audits for 4 weeks and will continue monthly for 3 months.

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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** This citation pertains to intake 2790806.Based on interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of staff to resident abuse to other state agency according to state law in 1 (Resident #104) of 3 residents reviewed for abuse resulting in the nurse licensing department not being notified and officials being unaware of abuse allegations, and the potential for abuse to reoccur.Findings include: Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic pain, anxiety and dementia (a decline in mental ability in memory, reasoning, and communication). Review of Resident #104's facility reported incident (FRI) investigation summary revealed, . Date of event: Resident #104 was exhibiting agitation and increased pacing. Licensed Practical Nurse (LPN) CC requested Resident #104 go to her room and stay there as heard by witness. Resident #104 refused to go to her room. Resident #104 approached LPN CC attempting to strike her. LPN CC placed Resident #104's arms behind her back and physically assisted her to her room and closed the door. Resident #104 vocalized stop that hurts . In depth analysis of how deficiency occurred: LPN CC was not using skills of de-escalation. Her frustration perpetuated the situation to intensify, resulting in verbal and physical abuse to the resident . Disciplinary action to be taken: termination effective 2/16/26. Noted that the FRI summary did not include documentation of the facility reporting LPN CC to the State Bureau of Professional Licensing. During an interview on 3/24/26 at 1:25 PM, Nursing Home Administrator (NHA) A reported that she had substantiated that LPN CC had verbally and physically abused Resident #104 on 2/4/26 based on witness interviews. NHA A reported that she terminated LPN CC on 2/16/26. When this writer queried NHA A as to if she had reported LPN CC 's termination to the State Bureau of Professional Licensing, NHA A reported that she could not recall if she had reported LPN CC. In a follow up interview on 3/26/26 at 1:30 PM, NHA A confirmed that she had not reported LPN CC to the State Bureau of Professional Licensing. NHA A reported she had completed the form to send to report LPN CC but that she had somehow forgot to fax the report, and this was just missed. According to the Michigan Public Health Code MCL 333.20175: (10) A health facility or agency that employs, contracts with, or grants privileges to a health professional licensed or registered under article 15 shall report the following to the department not more than 30 days after it occurs: (a) Disciplinary action taken by the health facility or agency against a health professional licensed or registered under article 15 based on the licensee's or registrant's professional competence, disciplinary action that results in a change of employment status, or disciplinary action based on conduct that adversely affects the licensee's or registrant's clinical privileges for a period of more than 15 days. As used in this subdivision, adversely affects means the reduction, restriction, suspension, revocation, denial, or failure to renew the clinical privileges of a licensee or registrant by a health facility or agency. (b) Restriction or acceptance of the surrender of the clinical privileges of a licensee or registrant under either of the following circumstances: (i) The licensee or registrant is under investigation by the health facility or agency. (ii) There is an agreement in which the health facility or agency agrees not to conduct an investigation into the licensee's or registrant's alleged professional incompetence or improper professional conduct. (c) A case in which a health professional resigns or terminates a contract or whose contract is not renewed instead of the health facility or agency taking disciplinary action against the health professional.

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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** Based on observation, interview, and record review, the facility failed to implement care plan interventions for 1 (Resident #111) of 9 residents reviewed for care plan implementation resulting in the potential for further skin breakdown and worsening of pressure ulcers. Findings include: Resident #111Review of an admission Record revealed Resident #111 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic pain and cerebral Infarction with expressive aphasia (stroke causing damage to the brain, resulting in non-fluent, effortful speech while comprehension remains relatively intact). Review of Resident #111's Orders revealed, WOUND CARE: Right elbow wound: cleanse with NS (normal saline)/wound cleanser. Apply Dakins (wound cleanser) solution moistened gauze to wound bed. Cover with silicone bordered dressing. every day shift. Start date: 3/17/26. WOUND CARE: Wounds to right plantar foot and heel: Paint areas with Iodine/betadine solution (topical antiseptic). every day shift. Start date: 3/24/26 .Review of Resident #111's Care Plan revealed, Focus: (Resident #111) has actual impairment to skin integrity r/t (related to) decreased mobility, medical device related pressure, bowel incontinence (the involuntary loss of stool), diarrhea, left hemiplegia following cerebral infarction (paralysis of the left side of the body resulting from a stroke), obesity, moderate protein calorie malnutrition Date initiated: 1/15/26. Interventions: pressure reducing boots to BLE (bilateral lower extremities) as tolerated by guest. Date initiated:1/28/26 .Soft pillow boot to right elbow. elbow. Date Initiated: 02/28/2026 .Treatment to skin impairment per order. Date Initiated: 01/16/2026 . Turn and Reposition q2h (every 2 hours) and PRN (as needed), as tolerated by resident. Date Initiated: 01/15/2026 .During an observation on 3/25/26 at 8:00 AM, Resident #111 was lying in bed on her back. Noted that Resident #111 was not wearing her pressure reducing boots on her feet, and they were sitting in her chair. During an observation on 3/25/26 at 9:38 AM, Resident #111 was lying in bed on her back in the same position as previous observation. It was noted that Resident #111's pressure reducing boots remained in her chair, and that Resident #111's feet were lying directly on the bed and not being floated over pillows or anything else to reduce pressure. During an interview on 3/25/26 at 1:13 PM, Certified Nursing Assistant (CNA) MM reported Resident #111 had multiple pressure ulcers, and that she was supposed to wear a pressure reducing pillow on her right arm and both feet at all times. CNA MM reported that Resident #111 tolerated the pressure reducing pillows well, and she had never witnessed kick her pressure reducing boots off. During an interview on 3/25/26 at 1:07 PM, Wound Care Nurse Practitioner (WCNP) DD reported he had been caring for Resident #111's pressure ulcers weekly for the last few months. WCNP DD reported that Resident #111 was high risk for worsening skin breakdown, and following pressure reducing interventions as ordered was crucial to prevent further skin breakdown. WCNP DD reported that Resident #111 was ordered to have a soft pillow boot on her right arm and pressure reducing boots to both feet at all times to help offload pressure. During a wound care observation and interview on 3/25/26 at 3:46 PM, Registered Nurse (RN) S had entered Resident #111's room to provide care to her wounds. RN S removed Resident #111's soft pillow on her right arm, Resident #111's right elbow wound was revealed to be open to air without any dressing on it. RN S looked around Resident #111's bed and floor to see if a bandage had fallen off and was not able to find a missing dressing. During an interview on 3/25/26 at 3:26 PM, LPN Q reported that the CNA's at the facility were not the best at communicating when they removed a soiled dressing or noticed the dressing had become dislodged if they were soiled or during care and not letting the nurse know so that they could apply a new dressing. Review of the facility's Care Planning policy last revised 6/24/21 revealed, Purpose: Every resident in the facility will have a person-centered plan of care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared for by the interdisciplinary team .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER: The Laurels of Sandy Creek		STREET ADDRESS, CITY, STATE, ZIP CODE: 425 E Elm St Wayland, MI 49348	

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate care for residents who received enteral nutrition (method of delivering nutrients directly into the gastrointestinal (GI) tract via tubes) in 1 (Resident #121) of 1 resident reviewed for enteral nutrition, resulting in the potential for aspiration pneumonia and spoiled tube feeding. Findings include: Resident #121Review of an admission Record revealed Resident #121 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic pain and dysphagia following cerebral infarction (difficulty swallowing following a stroke). Review of Resident #121's Orders revealed, Enteral Feed Order at bedtime Jevity1.5 (type of enteral nutrition formula) @80ml/hr (at milliliters per hour). Start date: 2/14/26 . Enteral Feed Order every shift Elevate head of bed at least 30 degrees during feeding. Start date: 1/21/26.Review of Resident #121's Care Plan revealed, Focus: (Resident #104) is unable to tolerate nutritionally adequate food and/or fluids by mouth requiring the use of a feeding tube R/T: dysphagia following cerebral infarction, moderate protein calorie malnutrition .Date initiated: 1/15/26 Goal: resident will remain free of aspiration . Interventions: resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. Date Initiated: 01/15/2026.During an observation on 3/25/26 at 8:00 AM, Resident #121 was lying in her bed sleeping. Noted that Resident #121's room tray had two opened bottles of Jevity formula sitting on it. Both bottles were 1/4 full. One bottle was dated 3/24/26 and the other bottle was not dated. Resident #121's tube feed was running at 80 mL/hr. Noted that the bag of formula that was running was not labeled or dated to indicate when the formula was opened. Resident #121 was lying flat. In an observation and interview on 3/25/26 at 8:04 AM, Licensed Practical Nurse (LPN) I reported that he was the nurse caring for Resident #121 today, but that he had not been into Resident #121's room to see her yet. LPN I entered Resident #121's room with this writer and stated that Resident #121 was definitely lying way too flat and he re-positioned Resident #121's head of the bed to be elevated to 45 degrees. LPN I reported that he had no idea how long Resident #121 had been lying flat while her enteral feed was running. It was noted that LPN I did not provide further assessment of Resident #121. When this writer queried LPN I about the open Jevity containers in Resident #121's tray table, LPN I reported that they should have been discarded. LPN I reported that nurses were supposed to date enteral feeding formulas when they were opened with the date and time to ensure that the formula being administered was safe to use and not spoiled. During an observation on 3/25/26 at 9:38 AM, Resident #121 was lying in bed. It was noted that her enteral feed was still running at 80 mL/hr, and the formula bag remained undated/unlabeled. During an observation on 3/25/26 at 1:13 PM, Resident #121 was lying in bed. It was noted that her enteral feed was still running at 80 mL/hr, and the formula bag remained undated/unlabeled. During an observation on 3/26/26 at 7:58 AM, Resident #121 was lying in her bed with her tube feed running at 80 mL/hr. It was noted that the formula bag did not have a date on the formula bag to indicate when the formula was opened, or what time the enteral feeding was started. Resident #121's head of bed was not elevated to 30 degrees. During a care observation on 3/26/26 at 8:12 AM, LPN Y reported that she was caring for Resident #121 that day, and that she had been in her room shortly before to fix her tube feed. LPN Y entered Resident #121's room and adjusted Resident #121's head of the bed to 30 degrees. LPN Y confirmed that Resident #121's head of bed was not elevated to 30 degrees. Review of the facility's Enteral Feeding policy last revised 9/22/23 revealed, Policy: Residents maintain acceptable parameters of nutritional status . residents who are unable to feed themselves receive the necessary services to maintain good nutrition, including at times, enteral nutrition . Guidelines: 8. the resident should be in semi-Fowlers position (medical orientation where the patient lies on their back (supine) with the head of the bed elevated to a 30-45 degree angle) during administration and for 30 minutes to one hour after to prevent aspiration .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2738764 and 2707043Based on observation, interview, and record review the facility failed to maintain their roof in a safe, functional, and sanitary manner for 2 (Residents #112 and #113) of 4 residents reviewed for environment, resulting in dissatisfaction with living environment which affected all areas of the facility and an increased potential for contamination. Findings include:Resident #112: During an observation on 3/25/26 at 2:16 PM, in room [ROOM NUMBER] on the ceiling near the light fixture closest to the window there was a large, discolored orange stain that measured approximately 17 inches by 22 inches. The surface of the stain in many places appeared to have what looked like raised areas that indicated buildup of unknown material and/or deterioration of the ceiling. It was noted that a resident had belongings in this room but was out at the hospital. Review of Resident #112's brief interview for mental status, dated 2/12/26, was scored 15 which reflected he was cognitively intact. During an interview on 3/25/26 at 2:26 PM, Resident #112 reported he used to live in room [ROOM NUMBER] but had to move out of the room because of a ceiling leak that caused the light fixture to stop working. Resident #112 reported the leak caused him to have to move his bed and eventually had to move rooms. Resident #112 reported he liked his old room (room [ROOM NUMBER]) more and wanted to move back to it. Resident #112 reported his ceiling was leaking in December 2025 but reported it had started leaking prior to that. Resident #112 reported it had been an issue for over a year now. Review of Resident #112's Notice of Room Change, dated 12/17/2025, stated, This notice is to inform you that: We (The Facility) will be transferring you to another room.Current rooom (sic) 301B has a few leaks from roof, when able to be corrected resident wishes to return to room [ROOM NUMBER]B. Review of Resident #112's census report (shows room changes), undated, showed Resident #112 lived in room [ROOM NUMBER]B from 5/2024-12/17/25 and was moved to a different room on the 300s unit on 12/17/25. Review of the facility's Resident Council meeting minutes, dated 12/2/25, stated, Concerns: New: Leaks in rooms. Resident #113 Review of an admission Record revealed Resident #113 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic pain and depression. Review of a Minimum Data Set (MDS) assessment for Resident #113, with a reference date of 1/6/26 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #113 was moderately cognitively impaired. During an interview on 3/25/26 at 4:39 PM, Certified Nursing Assistant (CNA) K reported that she had concerns for staff and resident safety related to the facility's leaking roof. CNA K reported that the (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility had to frequently move residents because water would leak all over the facility, including into resident rooms. CNA K reported that she felt it was unsafe because there were several residents that were unable to ambulate well and were at an increased risk of slipping and falling onto puddles that leaked throughout the facility. CNA K reported that at times, the roof was leaking water into the facility's shower rooms, and that there were times when residents were getting dripped on from the leaking roof when they were being showered. During an interview on 3/25/26 at 3:07 PM, Former Director of Nursing (DON) X reported that facility roof had been leaking for months, and it had become a safety risk for the staff and residents at the facility. Former (DON) X reported that multiple residents had to be moved from to different rooms because the roof was leaking onto the residents and their belongings. DON X reported she was aware of one Resident (Resident #113) sustaining a fall in the facility due to slipping on water that was leaking from the roof onto the floor in his room. During an interview on 3/26/26 at 11:18 AM, CNA Z reported that the facility's roof had been leaking for over a year, but the leaking seemed to increase this winter. CNA Z reported that anytime it rained or snowed, the facility would have several buckets around the facility to catch the water, and that the staff were frequently moving residents to other rooms because the roof was leaking into resident rooms. CNA Z voiced safety concerns for staff and residents due to the leaking roof. Review of Resident #113's Incident Report dated 2/17/26 and documented by Licensed Practical Nurse (LPN) Q revealed, Incident Description: Resident observed on the in front of his chest of drawers, sitting on top of wash basin, water on the floor. Wheelchair in front of his right side and bed to his left. Regular socks on. Call light within reach. Area free of clutter. (Resident #104) stated he slipped on water when transferring self from wheelchair to bed . During an interview on 3/25/26 at 3:26 PM, LPN Q reported that she was the nurse caring for Resident #113 on 2/17/26 when he slipped in fell on water leaking from the roof onto the floor of his room. LPN Q reported she found Resident #113 lying on his floor near his bed and observed water on the floor near him. LPNQ reported that the facility's roof had been leaking for quite some time, and several residents had to be moved because water was leaking into their rooms. During an interview on 3/25/26 at 4:29 PM, Resident #113 reported that he did fall on 2/17/26 in his room. Resident #113 reported he had slipped on water that was leaking from the roof onto his room floor. Resident #113 reported the roof had been leaking water into his room for quite some time. Resident #113 reported that he did experience some pain after his fall, but that the pain was resolved after a few days. On 3/25/26 at 8:15 AM, an interview with the Nursing Home Administrator (NHA) found that roof leaks had affected most of the facility as the snow melted on the roof from the winter. The NHA stated that over time, short term repairs were able to be put in place as issues arose (regarding the condition of the roof), but a full replacement is now scheduled for next week. On 3/25/26 starting at 9:23 AM, an initial tour of the East hall found the following observations: empty resident room [ROOM NUMBER] was observed with black staining on the ceiling, numerous stained (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and discolored ceiling tiles were observed walking down the hall to the East wing, East wing nurses station was observed with missing and discolored tiles with a system in place consisting of a plastic tarp funneling water into a five gallon bucket located on the desk of the East nurses station, East wing medication room was observed with bubbling and chipping surfaces on the back wall of the room indicating heavy moisture damage to the area. On 3/25/26 at 10:02 AM, an interview with Maintenance Director (MD) KK found that he has been employed with the facility for about four months and has been trying to stay on top of what he can. MD KK stated the roofing vendor had used 28 tubes of caulk since the snow had melted (to seal up holes until the roof could be fully redone). At this time, the surveyor and MD KK went on top of the roof to observe the current condition of the roof surface. The roof was observed with hundreds of caulk spots throughout with numerous areas circled or outlined to show larger issues within the roof's surface. At this time, contractors were also observed on the roof assessing the project for next week. On 3/25/26 at 12:50 PM, observation of the main middle hall near the middle back door observed numerous discolored and dried out ceiling tiles. On 3/25/26 starting at 12:52 PM, observation of the [NAME] hall found the following: discolored and brown ceiling tiles across from resident room [ROOM NUMBER], discoloration in the ceiling tiles at the North end of the [NAME] hall, two light fixtures leading to the South end of the [NAME] hall were found with rust accumulation indicating leaking into the light, Further down the South end of the [NAME] hall found numerous tiles discolored around the roof top unit, the South end [NAME] hall Spa was found with bubbling and brown areas of the ceiling, the west hall medication room was observed with heavy discoloration and sagging of the ceiling tiles, and the [NAME] hall day room was observed with black and brown discoloration coming from the ceiling.