

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 05/09/2024
NAME OF PROVIDER OR SUPPLIER Laurels of Sandy Creek (the)		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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>Based on observation, interview, and record review, the facility failed to provide an environment that promoted and resident dignity in 1 (Resident #4) of 3 residents reviewed for dignity, resulting in the potential of feelings of humiliation, embarrassment, and loss of self-worth, and a negative psychosocial outcome for the residents impacting their quality of life.</p> <p>Findings include:</p> <p>Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, Promote Dignity and Self-Esteem. A sense of dignity includes a person's positive self-regard .attending to the patient's physical appearance promotes dignity and self-esteem. Cleanliness, absence of body odors, and attractive clothing give patients a sense of worth .allow patients to make decisions such as how and when to administer personal hygiene .and timing of nursing interventions. [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 721.</p> <p>Resident #4:</p> <p>Review of an Admission Record revealed Resident #4 was a female with pertinent diagnoses which included cerebral palsy, chronic pain syndrome, PTSD, sleep terrors, anxiety, depression, malignant neoplasm of the breast (breast cancer), and adjustment disorder with mixed anxiety and depressed mood.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 3/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated Resident #4 was moderately cognitively impaired.</p> <p>Review of current Care Plan for Resident #4, revised on 8/1/2022, revealed the focus, .Hx (History) of partial right mastectomy with delayed wound healing .(Resident #4) has a functional ability deficit and requires assistance with self care/mobility . with the intervention .Dressing: Resident requires substantial/maximal assistance with one helper for upper body dressing .</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235313
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/07/24 at 10:22 AM, Resident #4 reported she was not wearing a bra today as she did not have any available to her. Resident #4 reported she had reconstructive surgery on her breast due to breast cancer and one side was larger than the other and she was very self-conscious about the difference in the size of her breasts and wearing a bra allowed them to appear more equal in size. She reported she did not like to go without a bra. Resident #4 reported her bras had been going missing, they were sports bra type bras, and wanted to know where her bras were. She just wanted to know what was happening to her bras and the facility did replace them but that had been happening a lot and that takes time for the facility to replace them, and she did not want to go without a bra.</p> <p>During an observation of the laundry room, an interview with Certified Nursing Assistant (CNA) CC, at 10:45 AM on 5/7/24, found that she is a CNA, but laundry has had some issues with staffing, so she was helping out. When asked if there had been issues getting residents personal linens back to them, CNA CC stated that some laundry staff had left recently, and laundry was getting behind. Currently there were three loads of personals ready to be washed, both washers were full of personals and one dryer was full.</p> <p>An interview with Housekeeping Manager (HKM) Y, at 10:53 AM on 5/7/24, found that there had been some issues in the past making sure resident belongings make it back to them on time. HKM Y stated that labeling new admits was an issue for a while, but we have since changed our policy to make sure staff use the label maker right away when getting new clothes. At times we would get 5 or so new admits a week, and if we didn't stop what we were doing to label the new clothes they had a chance of getting lost or misplaced.</p> <p>An interview with Housekeeper FF, at 11:05AM on 5/8/24 found that staff labeled clothes as soon as they came in, but sometimes the labels fall off after so long, so we needed to check to make sure the labels were still secure and not peeling.</p> <p>An interview with HKM Y, at 11:11 AM on 5/8/24, found that staffing for laundry has been getting better, there were three people taking orientation and one person who is getting trained right now. HKM Y went on to state that we tried to have resident laundry back to the residents in a 24 hour period.</p> <p>In an interview on 05/09/24 at 10:35 AM, Resident #4 reported she had only gotten one bra that came back from the laundry. She had sent five of them to the laundry, three new ones, two older ones.</p> <p>During an observation on 05/09/24 at 10:37 AM, this writer observed the laundry area and observed two hanging carts with baskets which contained the personal laundry of residents. Between the two hanging cart was a laundry cart with a large amount of personal laundry which needed to be folded. The height was approximately three feet over the top of the rolling metal laundry basket. There were large amounts of laundry everywhere in which it impeded movement in the laundry area which was a longer narrow area with laundry in various stages on both side with only a path to walk through. Housekeeper I was sorting the soiled linen, and a new staff member was folding sheets, gowns, and towels/washcloths.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/09/24 at 10:38 AM, Housekeeper L reported she was working in the laundry two days a week and as a housekeeper the other two days. She reported the second shift laundry person was coming in at 10:00 AM to assist with the laundry. Housekeeper L reported she would help her look for the missing bras for Resident #4. Housekeeper L reported she tries to be good at getting the resident's personal laundry back to them within 24 hours because she knows some people do not have a lot of clothing and needed their clothing back.</p> <p>In an interview on 05/09/24 at 12:23 PM, Director of Nursing (DON) B reported the laundry department had someone retire and it had taken some time to replace them. DON B reported 90% of the housekeepers were new staff members who had started training. DON B the second shift laundry person became overwhelmed with the amount of laundry after another laundry staff member retired and she quit. DON B reported she did not understand why the nursing staff had not addressed Resident #4's concern on the day it had happened and ensured she had a bra, and she was not aware of the situation until someone reported to her earlier Resident #4 had her bras back in her room. This writer informed the DON the resident reported she had not received them back from laundry when interviewed earlier this day.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>41027</p> <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to follow professional standards of practice for medication administration and documentation in 6 of 10 residents (Resident #7, #14, #22, #38, #39, and #50) reviewed for medication administration, resulting in the potential for medication errors.</p> <p>Findings include:</p> <p>During an observation on 05/09/24 at 09:10 AM of medication administration with Registered Nurse (RN) X and the east unit medication cart, RN X picked up 2 cups with multiple pills in each and 2 syringes of insulin (medication for blood sugar control) from the cart, locked the cart and proceeded to walk down the hall, enter a resident room and hand one cup to Resident #38 and the other cup to Resident #22. No observation of RN X confirming medications and/or identification of residents, and the medication cups were not labeled with the resident's name.</p> <p>During an observation and interview on 05/09/24 at 09:21 AM of medication administration, RN X documented administration of multiple medications for Resident #7, Resident #39, and Resident #50. RN X explained that Resident #7 had refused his medications before breakfast that day, Resident #39 had already gotten her medications earlier that day, and Resident #50 had received his medications from Licensed Practical Nurse (LPN) Z before she left that day. LPN Z had worked third shift.</p> <p>During an observation on 05/09/24 at 09:31 AM on east unit, RN X was preparing medications for Resident #14. RN X visualized Resident #14's orders on the computer, pulled Tylenol, Stool Softener, Fish Oil, Lasix (increases production of urine), and Finasteride (for urinary retention) from the cart, then closed the computer. RN X then opened another drawer, and grabbed Breo inhaler (for breathing). Then unlocked the narcotic box and pulled out Pregabalin (pain medication). RN X did not compare the medications with the physician orders, and did not check off the medications as they were pulled. RN X proceeded to administer the medications to Resident #14, then came back to the computer and checked off each medication and saved the record.</p> <p>In an interview on 05/09/24 at 09:55 AM, RN X reported that she did not know the facility policy related to the expectations for how and when to document medications in the record, and that she did not see any concern with giving medications to two residents at the same time. RN X reported that she should not have documented medications that she did not administer.</p> <p>An attempt was made on 05/09/24 at 01:52 PM to contact LPN Z to discuss why she did not sign out medications that were administered. Message was left, but no return call received.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/09/24 at 02:16 PM, Director of Nursing (DON) B reported that the expectation for medication administration was for nurses to compare each medication with the order in the computer, double check that the medication card matches the order, and then click off each medication on the Medication Administration Record (MAR) as they are pulled, then locked the computer screen, identify the resident, administer the medication, and lastly save the medication administration in the computer immediately following administration. DON B reported that preparing medications for two residents at the same time would risk administering the medications to the wrong resident, and was not facility procedure or policy. DON B reported that nursing staff were only authorized to sign medication administration for medications that they give, and should not sign out medications that were given by another nurse.</p> <p>Review of facility document, Medication Pass-Survey Preparedness revealed, .5. Identify guest by checking photo in med book and asking guest to state his or her name. 6. Verify medication and strength with order on MAR (3 times). 7. Pour meds immediately prior to administration, not before . 10. Initial med sheet immediately after administration .</p>		