

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 05/21/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>38666</p> <p>Based on observation, interview, and record review the facility failed to perform a resident self-administration assessment and obtain a physician order for the self-administration of medication for 1 (Resident #5) of 18 residents reviewed for self-administration of medication, resulting in the potential for the mismanagement of medication and potential for adverse side effects.</p> <p>Findings include:</p> <p>During an observation and interview on 05/21/25 at 08:05 AM, Resident #5 had 8 pills/medications in a plastic disposable medication administration cup next to her meal on her meal tray in her room. Resident #5 was alone in her room and reported the medications were provided to her by a nurse before breakfast, but she just hadn't taken them yet. There was no facility staff in the room or in the hallway outside of the room.</p> <p>During an observation and interview on 05/21/25 at 08:31 AM, Licensed Practical Nurse (LPN) BB was preparing medications to be given to other residents at the opposite end of the hall past the nurse's station from Resident #5's room. LPN BB confirmed she provided Resident #5 medications earlier that morning and thought Resident #5 had taken her medications. LPN BB, stated, I don't know what happened this morning in regards to medications being left in Resident #5's room without staff present to ensure administration occurred. LPN BB walked down the hall to Resident #5's room and stated to Resident #5, I thought we took these (medications) this morning. LPN BB then removed the medication cup with the 8 pills/medications from Resident #5's room. LPN BB confirmed the 8 pills/medications that were left unattended in Resident #5's room were buspirone (anxiety medication), duloxetine (depression medication), ferrous gluconate (iron supplement), furosemide (Diuretic; lowers blood pressure and fluid retention), lisinopril (heart medication), metformin (diabetes (blood sugar) medication), metoprolol (hypertension medication) and Tylenol (pain reliever). LPN BB confirmed Resident #5 hadn't had a medication self-administration assessment completed so she wasn't supposed to have medications in her room without staff present.</p> <p>During an interview on 05/21/25 at 08:43 AM, Director of Nursing (DON) B reviewed Resident #5's record and confirmed Resident #5 hadn't had a medication self-administration evaluation and she would need one completed to self-administer medications. DON BB confirmed Resident #5 shouldn't have been left alone with medications on her meal tray in her room.</p> <p>Review of Resident #5's most recent brief interview for mental status score, dated 4/27/25, was 13 which indicated cognitively intact.</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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Medication Administration policy, revised 10/17/2023, stated, Authorized Personnel - Medications are .administered .only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications .Self-Administration - residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with the guideline for self-administration of medication. A self-administration evaluation will be completed prior to the resident starting the self-administering process. Self-administration of medication will be reflected in the resident care plan along with any special considerations .Observe that the resident swallows the oral medications. Do not leave medications with the resident to self-administer unless the resident is approved for self-administration of the medication.</p>

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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on interview and record review, the facility to follow advance directive wishes for 1 (Resident #278) of 24 residents reviewed for advance directives, resulting in Resident #278 receiving cardiopulmonary resuscitation (CPR) when Resident #278 had an Do Not Resuscitate (DNR) order in place.</p> <p>Findings include:</p> <p>Resident #278</p> <p>Review of an Admission Record revealed Resident #278 was originally admitted to the facility on [DATE] with pertinent diagnoses which included shortness of breath.</p> <p>Review of Resident #278's Orders revealed, No CPR/DNR. Order Date: [DATE].</p> <p>Review of Resident #278's DNR Order dated [DATE] revealed, Do-Not-Resuscitate Order. This do not resuscitate order is issued by (local physician), attending physician for (Resident #278). A. Declarant Consent- Resident is their own person. I have discussed my health status with my physician named above. I request that in the event my heart stopped beating and breathing should stop, no person shall attempt to resuscitate me. This order will remain in effect until it is revoked as provided by law. Being of sound mind, I voluntarily execute this order, and I understand its full import. This order was signed by Resident #278 on [DATE]</p> <p>Review of Resident #278's Progress Notes dated [DATE] and documented by Licensed Practical Nurse (LPN) I revealed, At 6:50 PM this nurse heard a yell for help from CNA (Certified Nursing Assistant). This nurse reported to pt's (patient)(Resident #278) room where pt was in bed head back, eyes open, no respirations, circumoral cyanosis (blue discoloration around the mouth that can be caused by poor circulation or low oxygen levels in the blood), radial pulse absent, pt laid back and carotid pulses absent, confirmed by two staff this nurse yelled for code status and initiated CPR as status was undetermined. multiple people responded and DNR confirmed. Est: (estimated) 45 seconds of compressions administered during that time faint pulse was felt this nurse immediately withdrew from compressions, pt began agonal breathing (abnormal and labored breathing), head of bed raised and pt began to take effective breaths. during this time DON (Director of Nursing) B and multiple staff present and using tactile stimuli pt began to respond to app (appropriately) EMS (emergency medical services) appropriately (sic). BS (blood sugar) 288. O2 (oxygen saturation) 80% oxygen placed 3L (liters) pt 88%. EMS arrived pt explained situation does not recall anything from incident, the pt denies chest pain, and refuses transfer to higher care. Order received to continue O2 for 24 hours titration of oxygen L to maintain 92% or higher. prior to episode per CNA pt was transferred to bed via hooyer (a lift that transfers patients with limited mobility) pt was talking during and then began saying I can't breathe I cant breathe the pts eyes then rolled back and went flaccid, per CNA this is when they yelled for help. Pt's family was called by DON. Will follow up as necessary.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #278's EMS report dated [DATE] revealed, .Narrative: Per (facility) staff they were using the hoier lift to move the pt (Resident #278) from his chair to bed when he became unresponsive, stopped breathing and they couldn't feel a pulse. Staff states they finished the transfer to bed and started chest compressions. Per staff before they were able to provide 60 compressions the pt was awake and moving their hands from his chest .Pt reported he was his own person and did not wish to be transported. Pt also reported he is a DNR and was not sure why CPR was every (sic) performed .</p> <p>In an interview on [DATE] at 8:39 AM, LPN I reported that she had just started her shift on [DATE] when she heard a CNA yelling for help in Resident #278's room, and stating that he was not responding. LPN I reported that when she went into Resident #278's room, she observed Resident #278 lying in bed unresponsive. LPN I reported that she felt for a pulse on Resident #278 and confirmed that he did not have a pulse. LPN I reported that she yelled for staff to tell her what his code status was, and she began CPR on Resident #278. LPN I reported that as she was doing compressions on Resident #278, several staff members began running in and yelling that Resident #278's code status was DNR. LPN I reported that she stopped compressions as soon as she found out that Resident #278 had a DNR order. LPN I reported that she noticed Resident #278 started to gasp, and then she felt a pulse on him, and placed on oxygen on him. LPN I reported that she acted as she would if she had found someone in the street and did not know their code status, because it was taking too long for staff to tell her what Resident #278's code status was. LPN I reported that she had voiced concerns with the facility before about needing resident code status to be in more places than just the computer, but the facility had not initiated any additional places to find resident code status. LPN I reported that she thought she had completed about 45 seconds of compressions on Resident #278.</p> <p>In an interview on [DATE] at 1:31 PM, CNA H reported that she was caring for Resident #278 on [DATE] when he went unresponsive. CNA H reported that her and CNA N were transferring Resident #278 from his chair to his bed with a hoier lift when he began to say that he could not breathe. CNA H reported that they placed Resident #278 on his bed and sat the head of his bed up as they noticed that he went unresponsive. CNA H reported that she began yelling out for LPN I and as LPN H entered the room, she left to check to determine Resident #278's code status. CNA H reported that she ran out of the room and down to the nurses station to check the computer where she determined that Resident #278 had a DNR order. CNA H reported that she ran back to Resident #278's room and yelled that he had DNR, and then went to call 911. CNA H reported that she was the first staff member to tell LPN I that Resident #278 had a DNR order.</p> <p>In an interview on [DATE] at 2:05 PM, CNA N reported that she was caring for Resident #278 with CNA H on [DATE] when Resident #278 became unresponsive after they transferred Resident #278 from his chair to his bed. CNA N reported that as they laid Resident #278 in bed, he reported that he could not breathe and then went unresponsive. CNA N reported that she felt Resident #278's arm and could not find a pulse. CNA N reported that she and CNA H began yelling for help and LPN I entered Resident #278's room and also felt Resident #278's neck for a pulse, confirmed he did not have a pulse, and immediately began chest compressions on Resident #278. CNA N reported that after LPN I completed one round of compressions, LPN I checked Resident #278 for a pulse, and she reported that she felt a faint pulse. CNA N reported that she then checked Resident #278 and also felt a faint pulse on Resident #278. CNA N reported that as Resident #278 began to breathe again, several staff came in and reported that Resident #278 had a DNR order in place.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 1:11 PM, DON B reported that she was working on the evening of [DATE] and she ran to Resident #278's room when she heard staff yelling for help. DON B reported that when she went to Resident #278's room, she observed CNA H, CNA N, and LPN I' in Resident #278's room, and that Resident #278 was already beginning to wake up as she entered his room, and LPN I had already stopped performing CPR compressions on Resident #278. DON B confirmed that Resident #278 was unresponsive, did not have a pulse, and LPN I performed CPR on him, which did result in Resident #278 regaining a heartbeat. DON B reported that it was her expectation that staff would begin CPR on a resident until they verified the resident's code status. DON B confirmed that the facility did not complete an incident report, or initiate any further education after the incident with Resident #278 to improve the process of staff ensuring correct code status of residents in the event of emergencies.</p> <p>In an interview on [DATE] at 1:40 PM, Nursing Home Administrator (NHA) A reported that she was working on [DATE] when she had overheard a code blue being called for Resident #278. NHA A reported that she ran down to Resident #278's room and she saw LPN I, CNA N, and CNA H in Resident #278's room. NHA A reported that she ran to the nurses station and confirmed that Resident #278 had a DNR, and went back to Resident #278's room to report that he had a DNR, but that other staff were already there reporting his code status. NHA A reported that she had found out after the event that LPN I performed CPR on Resident #278 when he had an active DNR order in place. NHA A reported that the facility did not do an incident report after the event, but she thought that DON B had completed follow up education with staff. NHA A reported that she expected staff to confirm a resident's code status prior to initiating CPR. NHA A confirmed that Resident #278 was unresponsive, did not have a pulse, and LPN I performed CPR on him, which did result in Resident #278 regaining a heartbeat.</p> <p>Review of the Facility's CPR policy last reviewed [DATE] revealed, . Staff must maintain a current CPR certification for healthcare providers through a CPR provider whose training includes a hands on session in a physical instructor-led setting or a virtual instructor-led setting with hands-on demonstration in accordance with accepted national standards . 1. Validate the resident is full code and there is no DNR order .</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027</p> <p>Based on interview and record review, the facility failed to ensure 1 resident (Resident #6) of 24 residents received an accurate clinical assessment, reflective of the resident's status at the time of the assessment, resulting in inaccurate diagnosis of schizophrenia documented on MDS (Minimum Data Set) assessment.</p> <p>Findings include:</p> <p>Review of the MDS 3.0 RAI Manual v1.16, Chapter 1: Resident Assessment Instrument (RAI), revealed .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment .</p> <p>Resident #6</p> <p>Review of an Admission Record revealed Resident #6 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: depression.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #6, with a reference date of 3/14/25 revealed Active Medical Diagnosis of Schizophrenia.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #6, with a reference date of 12/15/25 revealed Active Medical Diagnosis of Schizophrenia.</p> <p>Review of Resident #6's Electronic Health Record indicated no diagnosis of Schizophrenia, no documented behaviors, and no treatment orders related to Schizophrenia.</p> <p>Review of Resident #6's PASARR (Preadmission Screening and Resident Review) (an evaluation to determine if a resident has serious mental illness and/or intellectual disability) indicated no mental illness and dementia exempt.</p> <p>Review of Resident #6's Behavioral Care Services note dated 9/11/2024 revealed, Major depressive disorder, recurrent severe without psychotic features, Dementia .WITHOUT behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>In an interview on 05/21/25 at 10:32 AM, Director of Nursing (DON) B reported that Resident #6 does not have any orders for psychotropic medications and does not have any behaviors indicative of schizophrenia.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/21/25 at 10:34 AM, Minimum Data Set-Registered Nurse (MDS-RN) V reported that Resident #6 had never received treatment for schizophrenia or behaviors. MDS-RN V reported that the diagnosis of schizophrenia was documented in error on multiple MDS assessments; MDS-RN V will modify the assessments and resubmit them.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on interview and record review the facility failed to ensure residents received care in accordance with professional standards in 1 of 18 residents (Resident #37) reviewed for quality of care when nursing staff administered Lotrel (Medication used to treat hypertension) out of the physician ordered parameters resulting in the potential for adverse side effects.</p> <p>Findings include:</p> <p>Resident #37</p> <p>Review of an Admission Record revealed Resident #37 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertension (high blood pressure).</p> <p>Review of Resident #37's Orders revealed, Lotrel Oral Capsule 10-40 MG (Amlodipine Besylate-Benazepril HCl) Give 1 capsule by mouth one time a day for HTN Hold if Systolic (systolic blood pressure) <110/ HR (heart rate)<60 .</p> <p>Review of Resident #37's Pharmacy Consultation Report dated 3/6/25 revealed, (Resident #37) has an order for Lotrel that was administered outside of the parameters for which it was ordered. Specifically, on 3/3, 3/4 when SBP (systolic blood pressure) was below 110. Recommendation: Please remind staff of the importance of administering/holding medication within the parameters ordered . This recommendation was signed by Director of Nursing (DON) B on 3/18/25.</p> <p>Review of Resident #37's Medication Administration Record for March, April, and May 2025 revealed that staff had documented administering Lotrel to Resident #37 when his systolic blood pressure was below 110 on 3/3/25, 3/4/25, 3/15/25, 3/19/25, 5/9/25 and 5/11/25. It was noted that Licensed Practical Nurse (LPN) G had documented the administration of the medication for each date except for 5/11/25.</p> <p>In an interview on 5/21/25 at 12:22 PM, DON B reported that she did not recall the pharmacy recommendation that she had signed for Resident #37 on 3/18/25. DON B confirmed that she had not completed any follow up education with nursing staff on ensuring that they were administering medications within the parameter orders.</p> <p>This writer attempted to reach LPN G on 5/21/25 at 12:50 PM for an interview. LPN G was unable to be reached prior to survey exit.</p> <p>Review of the facility's Medication Administration policy dated 10/17/23 revealed, Resident medications are administered in an accurate, safe, timely, and sanitary matter . Physician's orders: Medications are administered in accordance with written orders of the attending physician . Procedure: .</p>		

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<p>F 0801</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>38905</p> <p>Based on interview and record review the facility failed to employ a full-time Registered Dietitian or a Certified Dietary Manager to provide an oversight of kitchen and clinical nutritional services. This deficient practice has the increased potential to result in food service sanitation failures, foodborne illness, or inadequate assessment of high-risk residents.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen, starting at 7:50 AM on 5/19/25, it was found that Dietary Manager T still has a few more months to go until he completes his Certified Dietary Manger certification. When asked if he has been in the position for longer than a year, Dietary Manager T stated yes. When asked how often the dietitian comes to the facility, Dietary Manager T stated that the dietitian comes two days a week. When asked if he was aware that only one year was granted upon hire in the Dietary Manager / Food and Nutrition Supervisor role to obtain the Certified Dietary Manager certification, Dietary Manager T stated he thought he was allowed the length of the Certified Dietary Manager course, which is 18 months.</p> <p>A staff record review found no documentation that facility had a full time Certified Dietary Manager or full time Dietitian on staff.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>38666</p> <p>Based on observation, interview, and record review the facility failed to ensure resident food and drink preferences were honored consistently for 8 (Residents #5, 8, 17, 31, 35, 51, 54, 74) of 8 residents reviewed for dining, resulting in feelings of anger and sadness and the potential for weight loss and/or dehydration.</p> <p>Findings include:</p> <p>Resident #51:</p> <p>During an observation and interview on 05/19/25 at 08:11 AM, Resident #51 was eating breakfast in her room independently. Resident #51 was served hot tea while her meal ticket stated, 8 fl oz (fluid ounces) coffee. Resident #51 was visibly upset and reported she didn't want tea and wanted coffee. Resident #51 was also served a sausage patty, but Resident #51's meal ticket indicated, Dislikes: .Sausage. Resident #51 confirmed she didn't like sausage and didn't want the sausage served to her. Resident #51 was visibly frustrated and stated, It pisses me off, they (the staff) know it regarding food preferences not being honored. Resident #51 reported it was common she was given items that weren't consistent with her food preferences on the meal ticket.</p> <p>Resident #8:</p> <p>During an observation and interview on 05/19/25 at 08:23 AM, Resident #8 was eating breakfast in her room independently. Resident #8 reported she liked eggs every day. Resident #8's meal ticket stated, Standing Orders: .Scrambled Eggs but no eggs were provided at that meal. Resident #8 reported she didn't get her three coffee creamers as the ticket indicated. The meal ticket stated, Standing Orders: 8 fl oz (fluid ounces) coffee (Creamer X (times) 3). Resident #8 stated, You have to eat what you don't want to eat and reported it made her feel sad when her food and drink preferences weren't honored.</p> <p>During an interview on 05/21/25 at 09:32 AM, Dietary Manager T confirmed eggs were available at the 05/19/2025 breakfast meal and should have been provided to Resident #8.</p> <p>Resident #5:</p> <p>During an observation and interview on 05/19/25 at 09:21 AM, Resident #5 was eating breakfast independently in her room. Resident #5 was served a sausage patty, but her meal ticket stated, Dislikes: . Sausage. Resident #5 stated, .I don't like sausage.</p> <p>Resident #74:During an observation on 05/19/25 at 09:43 AM, Resident #74's meal was served to the resident in her room. The meal ticket indicated she disliked eggs, but eggs were served to her.</p> <p>Resident #35:</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 05/19/25 at 11:53 AM, Resident #35 was served a black pepper condiment pack but her dislikes on her meal ticket stated black pepper. Resident #35 reported she often is served black pepper, she dislikes the black pepper, doesn't use it, and felt it was wasteful to keep providing the black pepper to her.</p> <p>Resident #31:</p> <p>During an observation and interview on 05/20/25 at 12:05 PM, Resident #31 was eating lunch independently in the main dining room. Resident #31's meal ticket stated, Dislikes .Carrots . Zucchini but he was served carrots and zucchini in his mixed vegetables. He left them uneaten on his plate. Resident #31 reported he doesn't like carrots or zucchini and would have preferred something else.</p> <p>Resident #17:</p> <p>During an observation and interview on 05/20/25 at 12:06 PM, Resident #17 was independently eating lunch in the main dining room. His meal ticket noted he disliked lima beans, but he was served lima beans. Resident #17 confirmed he doesn't like lima beans.</p> <p>During an interview on 05/21/25 at 09:32 AM, Dietary Manager T confirmed 05/20/2025's lunch had mixed vegetables which contained Carrots .zucchini .lima beans.</p> <p>Review of the facility's Food Preferences, revised 1/9/2025, stated, Food preferences will be identified on tray tickets to ensure residents are provided with appropriate food items.</p> <p>46999</p> <p>Resident #54</p> <p>Review of a Nutritional Evaluation for Resident #54 with a reference date of 11/19/24 revealed Summary: . dx: COPD .regular diet .eat meals independently .ALLERGIC TO CUCUMBER AND PICKLES .</p> <p>In an interview on 5/19/25, at 10:04am, Resident #54 reported he was allergic to pickles and cucumbers and was concerned because although the facility was aware of his allergy, he recently received potato salad that contained pickles on his meal tray. Resident #54 reported he ate a few bites of potato salad before he realized it contained pickles. When further queried, Resident #54 reported in the past, he had become extremely nauseous and vomited violently for 30 minutes after he consumed pickles. Resident #54 reported in the past his body's reaction to eating pickles was exhausting to him, and he was worried that if he ate pickles now, in his state of worsened health, his body may not be able to tolerate it. Resident #54 reported I watch my food very carefully now because he was fearful about receiving pickles or cucumbers again in his meal.</p> <p>Review of a Kardex nursing care guide for Resident #54 with a reference date of 3/10/25 revealed Eating/Nutrition: Diet as ordered: regular diet, mechanical soft texture .easy to chew. Resident's food allergies were not listed.</p> <p>Review of the alert banner in Resident #54's medical record revealed Allergies . Cucumbers, Pickles.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a Meal Ticket for Resident #54 with a reference date of 5/20/25 revealed Allergies .pickles and cucumbers.</p> <p>During an observation on 5/20/25 at 12:33pm, Certified Nursing Assistant (CNA) J delivered Resident #54's lunch tray to him in his room.</p> <p>In an interview on 5/20/25 at 12:35pm, CNA J reported she regularly cared for Resident #54, and delivered his meals. CNA J reported was not aware the resident had any food allergies.</p> <p>In an interview on 5/20/25 at 1:59pm, CNA M reported Resident #54 watched his food very carefully because he was worried about mistakenly being served food that contained pickles or cucumbers again.</p> <p>Review of a Nurses Note for Resident #54 with a reference date of 4/19/25 revealed Resident has allergies to cucumbers/pickles. Resident (sic) reported that he noticed after a few bites of potato salad from dinner that there were pickles in it and immediately stopped eating and notified the nurse. Resident reported that mouth was slightly itchy .on call provider notified and ordered PRN (as needed) (name of antihistamine medication) and Ondansetron (anti-nausea) medication for 3 days. DON (Director of Nursing) and kitchen manager notified as well .</p> <p>Review of a Medication and Treatment Incident Report for Resident #54 with a reference date of 4/21/25 revealed Date of Incident: 4/19/25 .Route of Administration Involved: Pickles in potato salad .Description of Event: .resident took a couple of bites of potato salad .it had pickles .Resident c/o (complained of) itching in mouth . (antihistamine and anti-nausea medication) ordered. 2. Failure to Follow Procedure: allergy checking for meal ingredients .Corrective Action: Spoke with dietary manager .</p> <p>Efforts to contact the nurse who authored the Nurses Note and Medication and Treatment Incident Report where not successful at the time of the completion of the survey.</p> <p>In an interview on 5/21/25 at 9:30am, Dietary Manager (DM) T reported Resident #54 was mistakenly served potato salad that contained a known food allergen in April 2025. DM T reported the resident's food allergy was listed on his meal ticket at the time and the kitchen staff were expected to review the resident's food allergens as selected foods for the resident's meal tray. DM T reported the staff did not cross reference the ingredients list on the pre-made potato salad with Resident #54's food allergens on 4/19/25 when he was served food that contained pickles. DM T could not provide verification of any corrective action that was taken following the incident.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>38666</p> <p>Based on observation, interview, and record review the facility failed to ensure adaptive dining equipment was provided for 1 (Resident #5) of 3 residents reviewed for adaptive dining equipment resulting in difficulty eating and the potential for weight loss.</p> <p>Findings include:</p> <p>During an observation and interview on 05/19/25 at 09:21 AM, Resident #5 was eating breakfast in bed independently in her room. The meal ticket stated, Alerts: .built up utensils and it was highlighted yellow. Resident #5 was served breakfast with regular dining utensils/silverware; no built up utensils were provided. Resident #5 reported she can't remember the last time she used or was provided with built up silverware. Resident #5 was observed awkwardly handling a spoon. Resident #5 reported her right arm (dominant arm/hand) is hard to use after she had a stroke.</p> <p>During an observation and interview on 05/20/25 at 09:33 AM, Resident #5 was eating breakfast in bed. Resident #5's meal ticket indicated she should have been provided with built up utensils/silverware, but she was provided regular handled silverware. Resident #5 stated, I can't grab things the same way as she used to be able to. Resident #5 confirmed her right arm/hand was her dominant side that she used to eat with. Resident #5 picked up a fork and her grip on the fork appeared insecure. Resident #5 reported it would be easier to eat if she had the built up utensils/silverware. Resident #5 stated, I have a hard time hanging on to this (fork) as she was holding the fork in what appeared to be an awkward and insecure grip. Resident #5 was holding the fork to her palm with only her pointer and middle finger.</p> <p>During an observation and interview on 05/20/25 at 12:34 PM, Certified Nurse Aide J delivered Resident #5's lunch to her room and helped set up the meal. Resident #5 was served her lunch meal with regular silverware but her meal ticket indicated to provide built up utensils. Resident #5 appeared to have a weak handle on the fork. Resident #5 was very slow with her eating movements and appeared to be having difficulty utilizing her utensils effectively such as needing multiple attempts to pick up food items off the plate.</p> <p>During an observation and interview on 05/21/25 at 08:03 AM, Resident #5 was eating her breakfast meal in her room independently. Resident #5 was provided regular utensils/silverware but no built up utensils were provided. Resident #5 reported it would be helpful if she could get her built up utensils/silverware. Resident #5's meal ticket indicated to provide built up utensils.</p> <p>During an interview on 05/21/25 at 09:32 AM, Dietary Manager T confirmed Resident #5 was supposed to have received built up utensils with her all meals as she was ordered to have them.</p> <p>Review of Resident #5's most recent brief interview for mental status, dated 4/27/25, score was 13 which indicated cognitively intact.</p> <p>Review of Resident #5's medical diagnoses included a diagnosis of history of transient ischemic attack (is like a temporary stroke) and cerebral infarction (stroke), dated 8/5/2022.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #5's physician's orders included a diet order, revised 1/29/2025, that stated, Regular diet, chopped meat texture .built up utensils.</p> <p>Review of Resident #5's Nutritional Re-evaluation, dated 4/29/25, stated, .Adaptive Devices .foam built up utensils.</p> <p>Review of Resident #5's nutrition care plan included an intervention, revised 1/31/2025, that stated, Regular diet, Chopped Meat texture .built up utensils.</p> <p>Review of Resident #5's cognition care plan, revised 8/1/2024, stated, (Resident #5) is at risk for decline in cognition and has impaired cognitive function or impaired thought processes R/T: (related to) History of Stroke.</p> <p>Review of the facility's Adaptive Equipment (adaptive dining equipment) policy, revised 3/6/2024, stated, It is the policy of this facility to provide adaptive eating (dining) equipment for those residents who would benefit from their use .Culinary staff will place the adaptive equipment on each meal tray .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38905</p> <p>Based on observation, interview, and record review, the facility failed to maintain best practices in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen.</p> <p>Findings include:</p> <p>During a tour of the kitchen, at 8:10 AM on 5/19/25, observation of the clean utensil bins found that one of the bins was shown to have three utensils with stuck on and dried food debris. An interview with Dietary Manager T found that these containers get cleaned about weekly. Observation of the clean pots and pans at this time found one top with a faded date marking sticker labeled on the top. When asked if it should have come off when washed, DM T stated yes. Further review found a half pan with stuck on food debris on the side of the pan.</p> <p>Observation of large sheet pans stacked under the preparation table, at 8:13 AM on 5/19/25, found that most of the sheet pans were observed with encrusted grease caked on the inside corners of the pans. When asked if that is the cleanest the sheet pans get, DM T stated that staff tend to clean them in the dish machine and think that they need to scrub them by hand.</p> <p>During a tour of the East Pantry, at 8:50 AM on 5/19/25, it was observed that an ice chest was found stored in the room. When asked about the ice chest, DM T stated it was for water pass and the kitchen cleans it daily. Observation of the ice chest at this time found it full of ice and no way for water to drain as the ice melted.</p> <p>During a tour of the [NAME] Pantry, at 8:47 AM on 5/19/25, it was observed that the seal gasket of the refrigeration unit was found to be falling off and not connected properly in order to make a good seal.</p> <p>A revisit to the East Pantry, at 1:24 PM on 5/20/25, found the ice scoop stored right side up in the ice scoop holder.</p> <p>A revisits to the [NAME] Pantry, at 1:35 PM on 5/20/25, found the ice scoop stored right side up in the ice scoop holder.</p> <p>According to the 2022 FDA Food Code section 3-303.12 Storage or Display of Food in Contact with Water or Ice.(B) Except as specified in (C) and (D) of this section, unPACKAGED FOOD may not be stored in direct contact with undrained ice .</p> <p>According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.(B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>During an interview with DM T, at 8:22 AM on 5/19/25, it was found that the facility does not cool food regularly and that they don't log cooling for food saved from service.</p> <p>During an observation of the kitchen, at 8:28 AM on 5/19/25, it was observed that sausage patties from breakfast were placed in a gallon container with the top placed on it and left on the preparation table.</p> <p>A revisit to the kitchen, at 10:48 AM on 5/19/25, observed the container of sausage patties in the two door True cooler covered tightly with a lid with condensation found on the inside. The temperature of the product was taken and found to be 88F at this time. DM T stated that he will discard the food product.</p> <p>According to the 2022 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less .</p> <p>According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD.</p> <p>During the initial tour of the kitchen, at 8:33 AM on 5/19/25, observation of the kitchen chemical closet found that the faucet had a four-way splitter that was closed on all ends. Further observation found the water handles left on and constant back pressure of water being applied to the faucets internal vacuum breaker. When asked if staff use this chemical closet, DM T stated yes.</p> <p>According to the 2022 FDA Food According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.</p> <p>During a tour of the dish machine area, at 8:36 AM on 5/19/25, it was observed that two spray bottles with bright red quaternary ammonium sanitizers were found in this area. After testing the concentration of the bottles, they were found to be around 500 parts per million.</p> <p>According to the 2022 FDA Food Code section 7-204.11 Sanitizers, Criteria.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Chemical SANITIZERS, including chemical sanitizing solutions generated on-site, and other chemical antimicrobials applied to FOOD-CONTACT SURFACEs shall: (A) Meet the requirements specified in 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (Food-contact surface sanitizing solutions)P, or (B) Meet the requirements as specified in 40 CFR 180.2020 Pesticide Chemicals Not Requiring a Tolerance or Exemption from Tolerance-Non-food determinations.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46999</p> <p>Based on observation, interview, and record review, the facility failed to ensure the use of person protective equipment (PPE) (gown and gloves) by staff during high contact care activities for 1 (Resident #27) of 18 residents reviewed for enhanced barrier precautions (EBP) resulting in the potential for the spread of infection, cross contamination, and disease transmission.</p> <p>Findings include:</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #27 with a reference date of 3/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #27 was moderately cognitively impaired. Section GG revealed Resident #27 was dependent (2 or more helpers required) to transfer from the wheelchair to the bed. Section K of the MDS revealed Resident #27 had an abdominal feeding tube.</p> <p>Review of a Care Plan for Resident # 27 with a reference date of 4/17/25, revealed a need/goal/interventions of: Need: Diet changed to pureed texture. Goal: Will maintain adequate nutrition and hydration .Interventions: .administer tube feeding as ordered .Enhanced Barrier Precautions .</p> <p>Review of Physician Orders for Resident #27 revealed 1. Enteral feed, every shift Flush Peg tube . 2. Cleanse peg tube site with wound cleanser and apply dry dressing, start date 4/15/25 .3. ENHANCED BARRIER PRECAUTIONS, 4/15/25. The status of the orders was Active.</p> <p>During an observation on 5/20/25 at 9:26am, Certified Nursing Assistants (CNAs) M and K transferred Resident #27 from his wheelchair to his bed. CNA K then assisted Resident #27 with rolling to his right side while in bed and as she evaluated Resident #27's incontinence brief to determine if it was soiled. Throughout the high contact cares of transferring Resident #27, assisting him with positioning, and checking his brief, CNA M and CNA K wore gloves but no gown.</p> <p>During an observation on 5/20/25 at 9:31am, signage on Resident #27's door stated, Enhanced Barrier Precautions .staff must .wear gloves and a gown for the following High-Contact Resident Care Activities . Transferring .providing hygiene .changing briefs .</p> <p>In an interview on 5/20/25, at 9:33am, CNA M reported the facility had provided training on the use of PPE for resident's in EBP, but she had forgotten Resident #27 had those precautions. CNA M reported she and CNA K should have worn gowns and gloves when they transferred and provided cares to Resident #27 on 5/20/25 at 9:26am. CNA M reported she sometimes felt confused about EBP and sometimes didn't notice the signage posted on resident doors.</p> <p>In an interview on 5/21/25 at 11:04am, Director of Nursing/Infection Preventionist (DON/IP) B reported Resident #27 was on EBP which required the staff to wear a gown and gloves during any high contact care, including transferring and checking the resident's brief.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Enhanced Barrier Precautions policy with a reference date of 3/5/25 revealed Enhanced Barrier Precautions are indicated for residents with any of the following .a wound or indwelling device .Health care personnel caring for residents on Enhanced Barrier Precautions should wear gloves and gowns during high contact resident care. Examples of high contact resident care activities requiring gown and glove use: . transferring .providing hygiene .changing briefs .</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>38905</p> <p>Based on observation and interview, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living.</p> <p>Findings include:</p> <p>During a tour of the East Day room, at 9:43 AM on 5/19/25, it was observed that food crumbs, paper trash, and debris were found under and on the sides of seat cushions of two chairs and a love seat.</p> <p>During a tour of the East Hall Spa, at 9:53 AM on 5/19/25, it was observed that dried bowel movement was found stuck on the front bowl and seat of the commode. Further observation found an accumulation of dirt and debris behind the toilet in the back corner of the commode area and four wash cloths found stored on top of the paper towel holder next to the sink.</p> <p>During a tour of the [NAME] Hall spa room, at 10:42 AM on 5/19/25, it was observed that 12 wash cloths, four towels, and a box of gloves were stored on a shower chair next to the shower. Observation of the spa cabinet found a spray bottle of disinfectant stored over and next to clean and sanitary linens.</p> <p>During a revisit of the East Day room, at 9:04 AM on 5/20/25, observation of the chairs and love seat in this area found an accumulation of food crumbs, paper trash, and debris in the sides of the seat cushions. An interview with Laundry Director (LD) Q found that these areas should be cleaned daily.</p> <p>During a tour of the East side shower, at 9:09 AM on 5/20/25, observation of the commode found dried bowel movement on the front of the bowl and seat of the commode. Further observation found a stack of wash cloths stored on the paper towel holder. Observation of the cabinet found personal hygiene products stored with a bottle of cleaning disinfectant. When asked about items being stored together, LD Q stated that personal hygiene products should be stored in residents' rooms.</p> <p>During a tour of the [NAME] Shower room, at 9:21 AM on 5/20/25, it was observed that 14 towels and 12 wash cloths were found stored on a shower chair next to a shower. When asked if this is where clean linens are usually stored, LD Q stated no and that they should be stored in the cabinet to not get contaminated from residents showering.</p> <p>During a tour of the facility, starting at 1:35 PM on 5/20/25, observation of the following exit doors found gaps and spaces between the door, the door frame, and the installed weatherstripping. Doors noted with concern were the [NAME] hall North door (bottom), the [NAME] center South door (side), Center hall North courtyard door (bottom right), Dining Room exit door (left side), and the East hall North door (weatherstrip bent). These areas were found to allow the visible presence of light, air, and easy pest entry.</p>