STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Hudsonville (the)	3650 Van Buren Hudsonville, MI 49426

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37573 This citation pertains to intake M100147026 and M100146967. Based on interview and record review, the facility failed to provide daily medications for 1 (R2) of 3 residents reviewed for medication administration, resulting in the resident not receiving medications three times a week when they have dialysis in the mornings. Findings include: Review of a Face Sheet revealed R2 had pertinent diagnoses of hemiplegia and hemiparesis (one sided weakness), gastroparesis, and end stage renal disease. In an interview on 10/22/24 at 8:30 AM, Licensed Practical Nurse (LPN) B reported R2 was at dialysis at this time and will be back after noon. R2 has dialysis every Tuesday, Thursday, and Saturday mornings. The resident usually returns to the facility around noon time. Review of the Order Summary for R2 revealed no orders for dialysis. Review of the August 2024 Medication Administration Record (MAR) for R2 revealed she has the following medications ordered for 8:00 AM every day and did not receive them at all on the days she received dialysis (Tuesdays, Thursdays, and Saturdays) for the whole month. 1. 5 mg (milligrams) Amlodipine (blood pressure medication) 2. 300 mg Lamotrigine (bipolar medication) 3. 10 mg Lisinopril (blood pressure medication) 4. Multivitamin 5. 2.5 ml (milliliters) Famotidine (acid reflux) 6. 10 mg Claritin (allergy medication) 7. 7.5 ml Ferrous Sulfate Elixir 220 (44 Fe) (iron supplement) (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. 30 ml Fiber-Stat (constipation) 9. 5 mg Buspirone (anxiety), to be given three times a day and not given the morning dose. 10. 9000 units of Lactaid (lactose intolerant) 11. 300 mg Tigan (antiemetic) 12. 80 mg Simethicone (anti-flatulent), to be given three times a day and not given the morning dose. Review of the September MAR for R2 revealed the following medications ordered in the morning and not given on the days she received dialysis: 1. Amlodipine 2. 300 mg Lamotrigine (bipolar medication) to be given daily plus another order for 300 mg to be given on dialysis days starting 8/30/24. Missing additional doses on 9/4/24, 9/8/24, and 9/23/24. 3. Lisinopril 4. Multivitamin 5. Famotidine 6. Claritin 7. Ferrous Sulfate Elixir 220 (44 Fe) 8. Fiber-Stat 9. Buspirone 10. 5 ml Vitamin D3 10 mcg/ml (micrograms/ml) to be given twice daily at 8:00 AM and 4:00 PM and received a total of 9 doses out of 60 opportunities. 11. Metoclopramide 12. Tigan 13. Naphazoline-Pheniramine ophthalmic solution (for blepharitis- eye inflammation), 1 drop in each eye 4 times a day from 9/10/24 to 9/17/24 and missed 13 doses. 14. Simethicone Review of the October MAR for R2 revealed she did not receive her Claritin, ferrous sulfate, Fiber-stat, Lamotrigine, multivitamin, famotidine, vitamin D3, Buspirone, Lactaid, metoclopramide, Tigan, or Simethicone on her dialysis days of Tuesday, Thursday, and Saturday. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Hudsonville (the)	3650 Van Buren Hudsonville, MI 49426

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/23/24 at 2:15 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) reported they did not know why R2's once day medications were not given after dialysis or why a physician was not notified. They reported R2 should have received her daily medications after dialysis and will change the time of day she receives these medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235327	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Hudsonville (the)	3650 Van Buren Hudsonville, MI 49426

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 37573 This citation pertains to intake M100147026 and M100147319. Based on interview and record review, the facility failed to ensure appropriate measures were taken to maintain the patency of a Percutaneous Endoscopic Gastric/Jejunum (PEG/PEG/J) tube (a tube that enters the stomach/jejunum through the abdominal wall) and flushes administered as ordered, for 1 (R2), of 3 residents reviewed for PEG/J tube care, resulting in multiple PEG/J tube clogging incidents, several visits to the Emergency Department (ED), not following post hospital care instructions to ensure patency, and have a system in place to provide the continuity of care. Findings include: Review of a Face Sheet revealed R2 had pertinent diagnoses of hemiplegia and hemiparesis (one sided weakness), gastroparesis, and end stage renal disease. Review of Physician Progress notes dated 7/15/24 for R2 revealed: Abdominal exam revealed significant distention and general tenderness, with green bilious discharge leaking with some erythema noted surrounding tube insertion site. Concern for possible obstruction, perforation, tube dislodgement with order for [patient] to be sent to [Hospital]. Review of the electronic medical records (EMR) for R2 revealed the following: On 7/15/24, R2 went to the hospital for feeding tube problem (Per EMS (Emergency Medical Services)- Abd (abdominal) distention since Friday, bile leaking around J tube.) ED (emergency department) notes revealed: Drainage was likely due to the fact that the outer brace for the tube was not cinched tightly. Review of a Practitioner Progress note for R2, on 8/3/24 revealed, Nursing reports Resident PEG tube clogged. At first it was only the J port but after giving meds once through the Gastric tube and trying to give meds a second time, I was meeting resistance. I've tried aspirating both ports and I'm not getting anything. I've tried warm water for both ports but it's creating a bubble near the ports so I don't want to keep putting pressure on it. Review of the Hospital Records for R2 revealed on 8/3/24, R2 went to the ED and had the GJ tube replaced due to the tube being completely clogged and attempts to pass a wire through it was unsuccessful. Discharge instructions were sent home for care of the feeding tube that included to FLUSH TUBE WITH 50 mL OF WARM WATER AFTER ALL TUBE FEEDS AND MEDICATIONS TO PREVENT CLOGGING, flush the tube with water (any drinkable water is fine) before and after each feeding as well as between medications, medications in liquid form are safest, make sure crushed medications are totally dissolved, if not dissolved the tube may be clogged. The feeding tube will be regularly changed every 6 months. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Laurels of Hudsonville (the)		STREET ADDRESS, CITY, STATE, ZIP CODE: 3650 Van Buren, Hudsonville, MI 49426	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nursing Progress notes dated 8/6/24 at 10:27 AM for R2 revealed: Spoke to resident POA (Power of Attorney) with concerns on clogged tube. after looking into closed loop communication I believe (nurse) did not leave a note due to the 50 cc flush recommendation being input on 8/5/24 @ 11:04 PM . I then followed up with [Physician Assistant] regarding medication list to have non liquid medications to be changed to liquid form to prevent resident peg tube from clogging. I will continue to educate on the importance of properly crushing meds that are applicable and utilizing appropriate flushes to prevent clogging the peg tube. No documentation for educating nurses for care of R2's PEG tube was done. Review of the August Medication Administration Record (MAR) for R2 revealed an order to flush GJ tube every shift with 50 ml (milliliters) of warm water after all tube feeds and medication to prevent clogging started on 8/8/24. (5 days after last ED visit.) Review of the Nursing Progress notes for R2 dated 8/14/24 at 3:32 AM revealed: J-tube clogged, multiple attempts to unclog unsuccessful and sent to the ED. At 7:24 AM, Nursing Progress notes stated R2s GJ tube was clogged and flushed with a clog buster medication (at the hospital) and interventional radiology was not needed. Review of the Nursing Progress notes dated 8/14/24 at 7:45 AM for R2 revealed: HAD A MEETING WITH THE CLINICAL TEAM PER RESIDENT BEING SENT OUT TO UNCLOG G/J TUBE. AN INQUIRY ON GETTING SOME MEDICATIONS CHANGED TO LIQUID FORM WHERE APPLICABLE WAS DISCUSSED. AWAITING AN UPDATE. Review of the Practitioner Progress notes dated 8/14/24 at 00:00 for R2 revealed: Patient is seen to today for PEG tube clogging last PM [follow up]. Nursing reports [patient] has been frequently sent out to the ED over the past weeks overnight for clogged PEG tube site. Based on nursing, family reports and staffing, appears this likely related to training and education of PEG tube medication administration, with nursing team aware. Family reports ED suggested formulation change from tablet to liquid formulation. No documentation to show staff was educated. Review of the Nursing Progress notes for R2 dated 8/17/24 at 3:01 AM revealed: J-tube split when attempting to flush. It was decided by guardian and the DON (Director of Nursing) that tube would be taped and would have her tube stay that way until Monday when IR (interventional radiology) will be available in hospitals. 7:03 AM, J tube leaking continuously. Guardian did not want to send resident to the ER . Tube feeding was then infusing in the G tube for 4 hours and alternating to the drainage bag for 4 hours. No documentation that the physician was notified. 6:29 PM, The dietician was notified about changing tube feeding and orders a bolus of 160 mL's every 4 hours until tube is replaced. Review of the Nursing Progress notes dated 8/18/24 at 6:03 PM for R2 revealed: Contacted resident guardian about bolus feed d/t (due to) resident not tolerating them d/t pain, ABD (abdominal) distension and feed coming out through gastric bag. Guardian verbalized to not give 2000 bolus feed. A 2000 bolus feed is not what was ordered on 8/17/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Laurels of Hudsonville (the)		STREET ADDRESS, CITY, STATE, ZIP CODE: 3650 Van Buren, Hudsonville, MI 49426	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nursing Progress notes dated 8/19/24 at 7:32 AM for R2 revealed Spoke with PA (Physician Assistant) about revising any of the medications that can be switched to liquids. Spoke about putting in orders before 5pm today so that mediations could be sent in medication tote for delivery. Liquid medications still addressed/implemented since the 8/3/24 ED visit. At 8:27 AM, res transported to [ED] for tube replacement. Review of the Hospital Records dated 8/19/24 for R2 revealed: Pt's G/J tube is split and leaking; tube is taped together. Clogged GJ tube Review of a Physician Order dated 8/19/24 for R2 revealed an order for Pancrelipase tablet (as needed for Occluded enteral feeding tube with instructions. Not documented as used on the August MAR (Medication Administration Record). Several medications were ordered in liquid form on 8/19/24 and 8/20/24. Review of a Nursing Progress note dated 8/31/24 at 5:22 AM for R2 revealed: Noticed tube feed had bubbles in the container. I inquired with the night nurse and asked why are there bubbles in the tube feed container? He stated he did not know. I noticed that the G-Tube flushed great by gravity but the J-Tube did not by gravity so I notified the night nurse upon my findings. When I returned to the room I noticed the night nurse tried soft pulses with a syringe and warm water, I stated if resistance is met, stop immediately and told him I seen a clot buster in cart a few days ago. He retrieved the clot buster stated he understood the directions and administered it. 7:26 AM- Clogged J-tube would not flush 45 minutes after administering clot buster. 7:42 AM- Spoke to [Nurse Practitioner] I inquired as to what possibilities could clog the J tube she stated if the feeding stopped or did not flush could cause a clog. She recommended a manual flush every 4-6 hours to ensure it was working. 1:34 PM- Family came to the facility and got the J tube to work. Review of the Nursing Progress notes dated 9/13/24 at 2:02 PM for R2 revealed: Resident J tube clogged. Creon (clot buster) administered four times per orders and per facility provider. Sent to ED. Review of the Hospital Records dated 9/13/24 for R2 revealed: Gastrojejunostomy tube exchange. The patient's gastrojejunostomy tube s continuously needing exchange due to persistently being clogged by tube feeds and what appear to be crushed pills at her facility. Clear instructions were given to the facility on the discharge paperwork as to how to properly care for the tube and prevent continued clogging. Additionally, the gastric port should be used for decompression as there is a massive amount of retained gastric contents in the stomach. Review of a Nursing Progress note dated 9/29/24 at 10:30 PM revealed: Res daughter arrived to facility while this nurse was counting off the narcotic box with oncoming nurse. Daughter entered res room Daughter came out of room a few minutes later and informed both nurses that she had unclogged res feeding. Both nurses entered the room with daughter to observe tube. Daughter explained to both nurses that very hot water must be used in order to unclog the J tube, and further explained that she used water as hot as she could get it from the faucet.(sic) No documentation showing the physician was notified or the resident was assessed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Laurels of Hudsonville (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 3650 Van Buren Hudsonville, MI 49426	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nursing Progress note dated 10/1/24 at 2:30 PM for R2 revealed: DPOA stated that she had flushed both ports of the feeding tube without any staff present and observed fluid coming into the gastric bag from the J-port. Both myself and the Unit Manager went into residents room upon dpoa request in regards to the gastric bag and the J-port. No documentation indicating the physician was notified. In an interview on 10/23/24 at 9:32 AM, Registered Nurse (RN) I reported the PEG/J tube for R2 got clogged a couple of times for him. He did not know why the tubing would get clogged and suggested the tube feeding may have stopped for cares and not restarted timely. He reported he tried to flush the tubing and noticed there was some residual. When the tubing split on 8/13/24, RN I reported he must have pushed a little harder than he should have. RN I reported he did not know there was Creon at the facility to help unclog the tubing the first couple of times R2's PEG tubing was clogged. When he did use it, he realized he did not clamp the tubing after instilling the Creon, which caused the medication to not be effective because it would backflow to the other end of the tubing, away from the blockage. He reported he did not have a skills competency evaluation when he was hired earlier this year. On 8/19/24, RN I received education via Policy and Procedure for Medication Administration-Enteral Tube Feeding. No other nurses were educated on PEG/J tube care. In an interview on 10/22/24 at 11:30 AM, the Assistant Director of Nursing (ADON) reported RN I was re-educated about PEG/J tube care because the tubing kept getting clogged the POA (Power of Attorney) for R2 did not want him providing care for her until he was reeducated. The POA then wanted him removed from caring for R2. The ADON and the Director of Nursing (DON) did not know why the tubing kept getting clogged. When asked if they had the hospital records from each time R2 went to get a new PEG/J tube or was sent out to get her tubing unclogged, they denied having that information. No hospital records were in the EMR. The ADON reported the previous Unit Manager may have them in his office in a soft file. She later provided the information from the visit on 8/3/24 which only had the discharge instructions. She also had some information from the 9/13/24 and 9/23/24 hospital visits. There is no indication the floor staff were informed of hospital instructions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37573 This citation pertains to intake M100147026 and M100147319. Based on interview and record review, the facility failed to ensure appropriate competencies and skill sets were provided to care for one (R2) of 3 residents reviewed for Percutaneous Endoscopic Gastric/Jejunum (PEG/PEGJ) (a tube that enters the stomach/jejunum through the abdominal wall) tube care, resulting in repeated clogged tubes and several hospital trips. Findings include: Review of 5 Nursing Staff files revealed they had no current competency skills and assessments of nursing care, including residents with PEG/PEGJ tubes. 1. Registered Nurse (RN) I hired 2/7/24, 2. RN K hired 5/15/24, 3. RN A hired 8/8/24, 4. Licensed Practical Nurse (LPN) G hired 8/16/23, 5. LPN B had her last skills competency assessment done on 3/25/22. Review of a Face Sheet revealed R2 had pertinent diagnoses of hemiplegia and hemiparesis (one sided weakness), gastroparesis, and end stage renal disease. She also had a Percutaneous Endoscopic Gastric/Jejunum (PEG/PEG/J) tube. Review of the Electronic Medical Records (EMR) for R2 revealed she went went to the hospital on the following dates: 8/3/24 PEG/J tube clogged, went to ED to have it replaced. 8/14/24 PEG/J tube clogged went to ED and hospital unclogged it. 8/17/24 PEG/J tube split due to forced pressure, went to hospital on 8/19/24 for a new tube. 9/13/24 PEG/J tube clogged, went to ED to have it replaced. (continued on next page)

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Laurels of Hudsonville (the)	3650 Van Buren Hudsonville, MI 49426

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Nursing Progress notes dated 8/6/24 at 10:27 AM for R2 revealed: Spoke to resident POA (Power of Attorney) with concerns on clogged tube. after looking into closed loop communication I believe (nurse) did not leave a note due to the 50 cc flush recommendation being input on 8/5/24 @ 11:04 PM . I then followed up with [Physician Assistant] regarding medication list to have non liquid medications to be changed to liquid form to prevent resident peg tube from clogging. I will continue to educate on the importance of properly crushing meds that are applicable and utilizing appropriate flushes to prevent clogging the peg tube. No nursing education was documented as done. Review of the Practitioner Progress notes dated 8/14/24 at 00:00 for R2 revealed: Patient is seen to today for PEG tube clogging last PM [follow up]. Nursing reports [patient] has been frequently sent out to the ED over the past weeks overnight for clogged PEG tube site. Based on nursing, family reports and staffing, appears this likely related to training and education of PEG tube medication administration, with nursing team aware. Family reports ED suggested formulation change from tablet to liquid formulation. In an interview on 10/23/24 at 9:32 AM, Registered Nurse (RN) I reported the PEG/J tube for R2 got clogged a couple of times for him. He did not know why the tubing would get clogged and suggested the tube feeding may have stopped for cares and not restarted timely. He reported he tried to flush the tubing and noticed there was some residual. When the tubing split on 8/13/24, RN I reported he must have pushed a little harder than he should have. RN I reported he did not know there was Creon at the facility to help unclogged the tubing at the time when he was caring for R2. When he did use it, he realized he did not clamp the tubing after instilling the Creon and the medication would not be effective because it would backflow to the other end of the tubing. He reported he did not have a skills competency evaluation when he was hired earlier this year. In an interview on 10/22/24 at 11:30 AM, the Assistant Director of Nursing (ADON) reported RN I was re-educated about PEG/J tube care because the tubing kept getting clogged the POA (Power of Attorney) for R2 did not want RN I providing care for her until he was reeducated. The POA then wanted him removed from caring for R2. The ADON and the Director of Nursing (DON) did not know why the tubing kept getting clogged. On 8/19/24, RN I received education via Policy and Procedure for Medication Administration-Enteral Tube Feeding. No other nurses were educated on PEG/J tube care.