

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 08/26/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Hudsonville		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of abuse to the State Agency for one of four residents (Resident #1) reviewed. Findings:Resident #1(R1)Review of an admission Record revealed R1 was a [AGE] year-old female who was admitted to the facility on [DATE].Review of a Nursing Progress Note dated 08/24/25 revealed .Resident used her phone and called 911. CNA (certified nurse aide) walking by saw her on her phone and went in to investigate and noticed 911 was talking to her. CNA explained (to 911 dispatch) that resident was confused, and the call was an accident. Dispatch stated they needed to send an officer out to do a well-check. During an interview on 08/26/25 at 12:10 PM, the Administrator/Abuse Coordinator stated that she was not aware that R1 had called 911 on 08/24/25 nor was she aware that police came to the facility to interview R1 shortly after the call to 911. During an interview on 08/26/25 at 1:35 PM, Ottawa County Sherrif Deputy G reported that the narrative of the call made by R1 to 911 on 08/24/25 included the following: the resident stated she was being held against her will, resident stated she had been assaulted by staff, resident stated staff would not allow her to make phone calls, and the resident implied that she had been sexually assaulted by staff at the facility. During an interview on 08/26/25 at 1:00 PM, CNA B indicated her recollection of events on 08/24/25 that involved R1 were as follows: she (CNA B) was walking down the hallway and saw that R1 was in her room on the phone, CNA B went into R1's room and asked who she was talking to and R1 handed CNA B the phone. CNA B stated that 911 dispatch was on the phone and dispatch told CNA B that R1 reported being abuse by a staff person in the facility. CNA B told 911 dispatch that R1 was confused, R1 was ok, and the call was a mistake. CNA B also stated that she should have notified the Abuse Coordinator but didn't. During an interview on 08/26/25 at 12:51 PM, CNA A stated that she was working the evening of 08/24/25, was aware that R1 had called 911, and was told by CNA B that R1 had told 911 dispatch that she was being abused. CNA A also stated that she did not report the allegation of abuse to the Administrator/Abuse Coordinator because I assumed the nurse would take care of it.Review of the facility policy Abuse Prohibition Policy revealed .allegations of guest/resident abuse .shall be thoroughly investigated by the Administrator and reported to appropriate state agencies .allegations by anyone .must be immediately reported to the Administrator.</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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