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	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Hudsonville	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2794208. Based on interview and record review, the facility failed to honor a resident's DNR (do not resuscitate) wishes for one (R13) of 3 residents reviewed for advance directives, resulting in CPR (cardiopulmonary resuscitation) attempt after found unresponsive. Findings include: Resident #13 (R13)Review of a Face Sheet revealed R13 admitted to the facility on [DATE] with pertinent diagnoses of congestive heart failure, cognitive communication deficit, cardiomyopathy, enterococcus (bacterial infection) unspecified, and diabetes (listed as for primary admission). R13 passed away on [DATE]. Review of an Advance Directive document signed by R13 on [DATE] and by the physician on [DATE] revealed R13 requested no CPR (cardiopulmonary resuscitation). Review of the Order Summary in the EMR for R13 revealed the resident was documented as being a Full Code. Review of a LATE ENTRY Nursing Progress note ENTERED [DATE] at 11:43 AM for R13, back dated to [DATE] at 8:00 AM revealed: At approximately 0500, this nurse called to room [ROOM NUMBER] d/t Res. observed by CNA (Certified Nursing Assistant) not breathing. Approx. 0502- CODE BLUE paged via intercom.Upon entering room with AED (Automated External Defibrillator) and Crash cart, Res. observed in bed absent of HR (heart rate) or Respirations. Chest compressions immediately started by this Nurse. CNA instructed to activate EMS (Emergency Medical Services). 2nd night Nurse [XX] entered room to assist with CPR. Res. transferred to floor for more effective CPR measures. AED pads applied to Res. Bare chest, shock was not advised, CPR continued. Code status documentation reviewed and code status is DNR (do not resuscitate). A copy of the advance directive handed to MDS, CPR halted . In an interview on [DATE] at 11:36 AM, former Unit Manager/Registered Nurse (RN) K reported that the Electronic Medical Records (EMR) displayed R13 as a full code on the ribbon. When RN K was informed that R13 was a DNR, he searched the chart after Emergency Medical Services (EMS) took over CPR to locate the paperwork confirming R13's DNR status. EMS could not discontinue CPR without the documentation. RN K stated that the breakdown in the system occurred because the Social Workers were responsible for obtaining the consents and then updating the status in the EMR. RN K stated he should have caught the discrepancy beforehand but, as a Unit Manager, he was frequently pulled to the floor and could not adequately review charts, orders, and assist staff. In an interview on [DATE] at 12:13 PM, the Social Worker (SW) R explained that they had implemented a new system to ensure code status was updated to reflect residents' wishes. They updated it weekly and conducted audits. SW R provided the booklet and randomly selected 5 residents to review their code status, examined their Advance Directives, and confirmed the information matched what was documented in the EMR. Once the Social Workers obtained the codeˆstatus documentation, the Unit Manager changed the EMR to reflect the residents' wishes. SW R stated they did not have access to officially change information in the EMR, but the Nursing staff did. After the updates were made, the Medical Records department scanned the Advance Directives into the residents' charts. Review of the Advance Directives Policy and Procedure last revised [DATE] revealed: Procedure: A. Identify: On admission, the Facility will determine whether the Resident has executed advance directives. The Facility will also determine whether there (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was a DNR Order issued while in the facility. A Code Status Form will be signed to reflect the decision regarding CPR/DNR under the guidance provided below.B. Obtain Documents.I. Ascertain Resident's Care/Treatment Preferences: Social Services or designee will determine to the extent possible, whether the Resident has any wishes regarding the provision of health care and treatment and/or end of life decisions, review for any inconsistencies between documents, and document the same in the record. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: The facility identified on [DATE] R13 received CPR against his wishes.On [DATE], an audit was completed to review all current residents code status and supporting documentation evident in the EMR document tab. Any concerns were addressed immediately.On [DATE], nursing staff and social workers were educated on the Advance Directive Policy and Procedure.On [DATE] the first documented weekly audit began.The facility was able to demonstrate monitoring of the corrective action and maintained compliance as of [DATE].

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number 3021098Based on interview and record review, the facility failed to formulate a safe discharge plan for 1 Resident (R12) of 3 Residents reviewed for discharge.Findings included:R12Review of R12's admission record dated 6/2/26 revealed he was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included: peripheral vascular disease, pressure ulcer of left ankle (unstageable), pressure ulcer of left heel (unstageable), frontotemporal neurocognitive disorder, diabetes mellitus 2, with diabetic neuropathy (nerve damage), and acquired absences of right leg above knee (amputation of right leg). He was listed as his own responsible party.Review of R12's Brief Interview of Mental Status (BIMS), dated 4/13/26 revealed he scored 10/15 indicating he had moderate cognitive impairment.Review of R12's 72 Hour admission Conference dated effective 4/7/26 revealed the boxes for Attendees were checked for: Responsible Party/Family, Resident/Patient, Care Manager, Social Services. 4a. revealed, Patient will be LTC (long term care). 6a. Notes/Comments: SW: Patient is a LTC patient at this facility. He is his own decision maker. Code status is full resuscitation. He is taking psychoactive medications. No observed behaviors since admission. Resident admits as a SAR (Skilled Acute Rehab guest with plans to transition to LTC if rehabilitation does not reach the goals family has set to return home. Discussed no pork or beef on trays, resident chose DNR (Do-not-Resuscitate) status, awaiting work to see if resident or advocated signs the DNR paperwork. Advocate is concerned about capacity. Provider to evaluate capacity.Review of R12's hospital discharge paperwork revealed R12 named a family member Y his DPOA, Durable Power of attorney for medical on 3/5/24.Review of the hospital discharge records in the facility records, page 1, FAX date 3/13/26 at 1:05PM revealed, History of Patient Capacity Status Changes change on 3/13/26 incapacity, changed by name of a Registered Nurse (RN) V and a second note of change on 3/13/26 incapacity, changed by a name of a LLMSW (Limited Licensed Master Social Worker) W. After these statements two statements of capacity revealed. Comment At time of this written statement, it is felt that the patient does not possess the capacity to fully understand new clinical information regarding his health status, or to direct responsible medical decision making on his own behalf. Name of the physician T. Under that statement of revealed, The patient lacks capacity to safely understand or incorporate information to make informed medical decisions. I recommend that the DDPOA (Medical Durable Power of Attorney) be activated. Name of Physician U. The next statement revealed, Comment: At time of this written statement, it is felt that the patient does not possess the capacity to fully understand new clinical information regarding his health status, or to direct responsible medical decision making on his behalf. Signed again by physician T.Review of R12's Social Services Note dated 5/8/26 at 16:59 (4:59 PM) revealed, SW made report to APS (Adult Protective Services) today at 4:45 PM about possible unsafe conditions at his home . having 12 steps that he would have to go up and down. Also, the concerns of medication management due to his diabetes with his blood glucose being extremely high.Review of R12's Adv (advanced) Discharge GG (noting section of the Minimum Data Set (MDS) assessment, Evaluation revealed, IDT (Interdisciplinary Team) Collaboration included the following: MDS (Minimum Date Set) Nurse, Eating: Discharge Performance: Shower/bathe self: discharge performance: Supervision or touching assistance, upper body dressing: discharge performance: supervision or touching assistance. Lower body dressing: discharge performance: partial/moderated assistance. Putting on /taking off footwear: Discharge performance: supervision or touching assistance. Ability to come to a standing position from sitting position form sitting in a chair, wheelchair or on the side of the bed. Discharge performance: Supervision or touching assistance. The ability to transfer to and from a bed to a chair (or wheelchair): Discharge performance: supervision or touching assistance. Toilet transfer: The ability to get on and off a toilet or commode: Discharge performance: Supervision (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or touch assistance. Car transfer: Discharge performance: Not attempted due to medical condition or safety.During an interview with the facility Social Worker (SW) X on 6/2/26 at 10:06 AM, SW X reviewed R12's Hospital Discharge Incapacity statements and said the facility did not honor the hospital documentation because it was signed by an RN and SW. SW X said it takes two physicians to determine incapacity. SW X did not mention the statements signed by two physicians directly under the SW and RN statements which did indicate that R12 did not have capacity to understand his clinical information. SW X could not find any documentation where the facility reviewed safety concerns or the hospital documentation of capacity with the facility physician. SW X (reported) the facility physician did not revoke R12's DPOA, as SW X believed the DPOA papers the hospital provided were not legally binding. SW X was asked why she called APS on R12 the day after discharge 5/8/26 and SW X could not recall.During an interview with Licensed Practical Nurse (LPN) Z and SW X on 6/2/26 at 10:12 AM, LPN X said she verbally reviewed R12's medications with him on 5/7/26 and provided him a bag of medications that included insulin in vials and insulin in pens. LPN Z confirmed she never witnessed R12 giving himself insulin or other medications. LPN Z recalled R12 preferred insulin pens over insulin in vials. SW X and LPN Z confirmed that R12 signed himself out and was taken to his home by the facility driver on 5/7/26. LPN Z confirmed R12 was not independent with all his ADL's (Activities of Daily Living) and R12 was noncompliant with using has call light for assistance with transfers.During a telephone interview with R12's DPOA Y on 6/2/26 at 8:42 AM, DPOA Y said the facility did not honor R12's DPOA. DPOA Y said she agreed with R12 returning home if he could be safe independently including medication management. DPOA Y said the facility informed her R12 was signing himself out on 5/7/26 and she ensured the facility that family members would meet R12 at his home. DPOA Y said the facility driver left R12 in his wheelchair at the bottom of steps to his home. R12 scooted up the steps on his butt and family had to physically help him stand and get back into his wheelchair. Family could not locate any written discharge instructions. Family continued to stay with R12 for his safety, but when he could not independently care for himself or take his own medications, they took him to a hospital emergency room. DPOA Y said the hospital was very upset that the facility did not honor R12's existing DPOA paperwork and the hospital discharged R12 to a nursing home that does honor his DPOA paperwork.Review of a hospital complaint dated 5/8/26 revealed R12 was taken to the hospital by his DPOA when he failed his home discharge. The report listed the facility name and revealed R12 was not his own DPOA; however, signed himself out of the facility and family did not agree to his discharge at that time.In an interview on 6/2/26 at 1:30 PM, the Nursing Home Administrator (NHA) confirmed that she did not locate any documentation revoking R12's DPOA or documentation where the facility reviewed R12's safety concerns with the facility physician.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 3021098 and 2794208. Based on interview and record review, the facility failed to develop and implement a person-centered care plan for two (R13 and R12) of 3 residents reviewed for care plans. Findings include: R12 Review of R12's admission record dated 6/2/26 revealed he was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included: peripheral vascular disease, pressure ulcer of left ankle (unstageable), pressure ulcer of left heel (unstageable), frontotemporal neurocognitive disorder, diabetes mellitus 2 with diabetic neuropathy (nerve damage), and acquired absences of right leg above knee (amputation of right leg). He was listed as his own responsible party. Review of R12's Brief Interview of Mental Status (BIMS), dated 4/13/26 revealed he scored 10/15 indicating he had moderate cognitive impairment. Review of R12's hospital discharge paperwork revealed R12 named a family member Y his DPOA, Durable Power of attorney for medical on 3/5/24. Review of the hospital discharge records in the facility records, page 1, FAX date 3/13/26 at 1:05PM revealed, History of Patient Capacity Status Changes change on 3/13/26 incapacity, changed by name of a Registered Nurse (RN) V and a second note of change on 3/13/26 incapacity, changed by a name of a LLMSW (Limited Licensed Master Social Worker) W. After these statements two statements of capacity revealed, Comment At time of this written statement, it is felt that the patient does not possess the capacity to fully understand new clinical information regarding his health status, or to direct responsible medical decision making on his own behalf. Name of the physician T. Under that statement of revealed, The patient lacks capacity to safely understand or incorporate information to make informed medical decisions. I recommend that the DDPOA (Medical Durable Power of Attorney) be activated. Name of Physician U. The next statement revealed, Comment: At time of this written statement, it is felt that the patient does not possess the capacity to fully understand new clinical information regarding his health status, or to direct responsible medical decision making on his behalf. Signed again by physician T (showing two physicians signed the document). Review of R12's 72 Hour admission Conference dated effective 4/7/26 revealed the boxes for Attendees were checked for: Responsible Party/Family, Resident/Patient, Care Manager, Social Services. 4a. revealed, Patient will be LTC (long term care). 6a. Notes/Comments: SW: Patient is a LTC patient at this facility. He is his own decision maker. Code status is full resuscitation. He is taking psychoactive medications. No observed behaviors since admission. Resident admits as a SAR (Skilled Acute Rehab guest with plans to transition to LTC if rehabilitation does not reach the goals family has set to return home. Discussed no pork or beef on trays, resident chose DNR (Do-not-Resuscitate) status, awaiting work to see if resident or advocated signs the DNR paperwork. Advocate is concerned about capacity. Provider to evaluate capacity. During an interview with the facility Social Worker (SW) X on 6/2/26 at 10:06 AM, SW X reviewed R12's hospital discharge incapacity statements and said the facility did not honor the hospital (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation because it was signed by an RN and SW. SW X said it takes two physicians to determine incapacity. SW X did not mention the statement signed by two physicians directly under the SW and RN statements which did indicate that R12 did not have capacity to understand his clinical information. SW X could not find any documentation where the facility reviewed R12's safety concerns or the hospital documentation of lack of capacity with the facility physician. SW X reported the facility physician did not revoke R12's DPOA, as SW X believed the DPOA papers the hospital provided were not legally binding. During an interview with Licensed Practical Nurse (LPN) Z and SW X on 6/2/26 at 10:12 AM, LPN X said she verbally reviewed R12's medications with him on 5/7/26 and provided him a bag of Medications the included insulin in vials and insulin in pens. LPN Z confirmed she never witnessed R12 giving himself insulin or other medications. LPN Z recalled R12 preferred insulin pens over insulin in vials. SW X and LPN Z confirmed that R12 signed himself out and was taken to his home by the facility driver on 5/7/26, LPN Z confirmed R12 was not independent with all his ADL's (Activities of Daily Living) and R12 was noncompliant with using has call light for assistance with transfers. During a telephone interview with R12's DPOA Y on 6/2/26 at 8:42 AM, DPOA Y said the facility did not honor R12's DPOA. DPOA Y said she agreed with R12 returning home if he could be safe when living independently, including medication management. DPOA Y said the facility informed her R12 was signing himself out on 5/7/26 and she ensured that family members met R12 at his home. DPOA Y said the facility driver left R12 in his wheelchair at the bottom of the steps to his home. R12 scooted up the steps on his butt and family had to physically help him stand and get back into his wheelchair. Family could not locate any written discharge instructions. Family continued to stay with R12 for his safety, but when he could not independently care for himself or take his own medications they took him to a hospital emergency room. DPOA Y said the hospital was very upset that the facility did not honor R12's existing DPOA paperwork and the hospital discharged R12 to a nursing home that does honor his DPOA paperwork. 6/2/26 at 1:30 PM, the Nursing Home Administrator (NHA) confirmed that she did not locate any documentation revoking R12's DPOA or documentation where the facility reviewed R12's safety concerns with the facility physician. Review of R12's Care Plan revealed, (Name of R12) has a functional ability deficit and requires assistance with self-care/mobility R/T (related to): recent AKA (above knee amputation). He also admitted with pressure ulcers on his left foot dated, 4/9/26. Interventions included: break tasks into smaller subtasks, encourage residents to use bell/call light for assistance, home safety visit prior to discharge, bath/shower: partial assist, ambulation/walking: resident is unable to ambulate and requires a wheelchair, for locomotion, bed mobility: supervision, dressing: supervision for upper body and partial assist for lower body, eating: set-up, personal hygiene (combing hair, shaving, applying makeup, nail care, and washing and drying face and hands): supervision, transfers:1 person slide-board transfers from wheelchair for safety, toilet hygiene: partial assist, toilet transfers, 1 assist person transfer with slide board form EOB (edge of bed) – commode with gait belt. All these interventions were still current when R12 discharged home independently on 5/7/26. There was no documentation of R12 being independent with these tasks and no documentation of a home evaluation prior to R12 discharging home independently on 5/7/26. Review of R12's care plan revealed, (Name of R12) wishes to return to the community. (name of the facility must: List any specifics that need to be accomplished before discharge can occur – especially if returning to a (group home) Discharge plan is uncertain at this time dated, 4/28/26 the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only intervention was, Prepare and give resident, family member, and/or care giver contact numbers for needed community referrals as needed. There was no indication of interventions and goals related to a safe discharge home independently. R13 Review of a Face Sheet revealed R13 admitted to the facility on [DATE] with pertinent diagnoses of congestive heart failure, cognitive communication deficit, cardiomyopathy, enterococcus (bacterial infection) unspecified, and diabetes (as listed for primary admission). Review of the Care Plan for R13 revealed the following: Special Instructions: Meds: Whole admitted here for short term rehab following hospitalization for UTI (urinary tract infection). he also has CAD (coronary artery disease), CHF (congestive heart failure), HTN (hypertension), DM (diabetes mellitus), sleep Apnea and Anemia. PLEASE document on s/s's (signs and symptoms) of UTI, pain, safety awareness, ability to compete ADL's and participation in therapy. TELEMED CONSENT 06/13/2025. - Need: (R13) is at risk for cardiac complications related to multiple cardiovascular diseases: CAD (coronary artery disease), HTN (hypertension), Afib (atrial fibrillation), initiated on 6/14/15 and revised on 6/24/25. Review of the Care Plan for R13 revealed: - Need: (R13) is at risk for pain. He generally denies any discomfort. Initiated 6/16/25. Interventions included: Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Does not address acute verses chronic pain or the location of pain. No Care Plan that addresses comorbidities for R13 including but not limited to CHF, bacteremia/sepsis, sleep apnea, anemia, or Advance Directives.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: 2794208, 3001098, 3005108 and 2711826 Based on interview and record review, the facility failed to 1.provide care and services to ensure abnormal laboratory values were addressed, 2. Implement resident directed care for CHF (congestive heart failure) and bacteremia sepsis (blood infection), 3. Recognize, assess, and address the resident's condition, 4. Monitor, evaluate, and revise responses to interventions as appropriate, 5. Provide appropriate physician oversight, and 6. Honor the advance directives for two (R1 and R13) of 3 residents reviewed for quality of care, resulting in the unexpected death of a resident (R31) and medication not being provided as ordered (R1). Findings include:Review of a Face Sheet revealed R13 admitted to the facility on [DATE] with pertinent diagnoses of congestive heart failure, cognitive communication deficit, cardiomyopathy, enterococcus (bacterial infection) unspecified, and diabetes (as listed for primary admission). Review of an Advance Directive document signed by R13 on [DATE] and by the physician on [DATE] revealed R13 requested no CPR (cardiopulmonary resuscitation). Review of the Order Summary in the EMR for R13 revealed the resident was documented as being a Full Code. In an interview on [DATE] at 6:04 AM CNA J reported she cared for R13 during the night of [DATE] through the morning of [DATE]. She remembered that R13 had trouble breathing throughout the night. She took his vital signs several times, noted they were not good, and observed that his oxygen level was low. RN K remained in the office with the ADON most of the night, and each time CNA J knocked on the door to ask him to assess R13 and presented the latest vital signs, RN K became upset. RN K told her he would give R13 a breathing treatment and then placed his CPAP (Continuous Positive Airway Pressure machine for treating sleep apnea) mask over the nasal cannula, even though the mask would not seal properly. R13 repeatedly said he could not breathe with the CPAP on his face, and RN K told him to give it a few minutes. CNA J stayed with R13, took his vital signs again, and approached RN K to suggest sending R13 to the hospital. RN K responded that he does not send anyone out on his watch. CNA J reported that she and another CNA continued checking on R13 every 10 to 15 minutes while RN K stayed in his office. She believed R13's condition was serious, but the other nurses (RN K and the former ADON) did not treat it that way. Between 4:30 and 5:00 AM, CNA J went to check on R13 one last time before beginning her rounds on the other residents and found him unresponsive. She informed RN K and code blue was initiated at that time. Laboratory ResultsReview of the Hospital Transfer of Care Document for R13 with a discharge date of [DATE] revealed the following Hospital Problems Present: *(Principal) Bacteremia due to Enterococcus (blood infection), AKI (acute kidney injury), Aortic stenosis, Bacteremia, CAD (coronary artery disease), Chronic combined systolic and diastolic heart failure (CHF), Type II Diabetes mellitus (DM), Hypertension (HTN), Nonischemic cardiomyopathy (abnormal enlargement of the heart muscle), paroxysmal atrial fibrillation (episodes of fast irregular heart beat), Right ureteral stone. Status post right ureteral stent, . stent in appropriate position, stone in similar position; bladder appears distended, Worsening renal function, Urine [culture] positive for enterococcus faecalis, 1/2 [blood cultures] positive for enterococcus faecalis, [status post] cystoscopy . Labs on [DATE] at 7:45 AM- HGB 7.4 (low), HCT 23.1% (low), .Discharge Instructions: . Continue IV (intravenous) antibiotics that were ordered prior to his admission, 2 weeks of abx (antibiotics) from 6/8 (EOT 6/22). Review of the Order Summary for R13 revealed on [DATE] a onetime order to obtain a CBC (complete blood count) with differential, CMP (comprehensive metabolic panel), BNP, and a lipid panel. Review of the Laboratory tests collected on [DATE] for R13 revealed a potassium 4.9 mmol/L (millimole/liter) (normal 3.5-5.5), BNP of 1368.9 pg/ml (picograms/milliliter) (flagged as a double high value (normal is <100)), HBG 7.7 g/dl (grams/deciliter (normal 13.7-17.0)) and flagged as a double low value, and HCT (hematocrit) 24.5% (normal 40.5-49.7), CO2 (carbon dioxide) 22 (normal 18-33), neutrophils 82.1% (normal 43.4 - 76.2, indicating an infection). No documentation indicating the practitioner acknowledged and addressed the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	abnormal lab values. Review of a Practitioner Progress note dated [DATE] at 00:00 for R13 revealed it was an Acute and a new patient visit (not in person). came to the [Facility] following a hospital stay for a kidney stone and AKI (acute kidney injury) following lithotripsy. He also suffers from systolic and diastolic CHF. Normally has stage 3b kidney failure. oxygen saturation 91% (normal 95-100%) Does not address abnormal preadmission labs or the abnormal labs drawn on [DATE]. Review of a Practitioner Progress note dated [DATE] at 00:00 for R13 revealed: Visit Type: Telehealth- Asynchronous . Labs reviewed. Did not indicate which labs were reviewed or a plan/order that acknowledged the abnormal laboratory values. Review of a Practitioner Diagnostic Result Review note dated [DATE] at 00:00 for R13 revealed: Date of review [DATE]. Lab or Image Type: COMPREHENSIVE METABOLIC PANEL / LIPID PANEL / BNP / CBC/DIFF & PLT / RBC. MORPHOLOGY. Plan of Action: started strict I & O s (input and output), started triamterene (diuretic) 50mg (milligrams) . Did not specify date of labs reviewed, did not acknowledge the abnormal labs, did not order parameters for I & O's, and did not establish a goal/baseline weight. Review of a Nursing Progress note dated [DATE] at 5:43 AM for R13 revealed: Resident c/o (complains of) SOB (short of breath) at [3:30 AM], VS (vital signs) 127/79 (blood pressure), P (pulse) 103 (normal 60-100), T (temperature) 99.1 (normal 98.6 degrees Fahrenheit), SaO2 (oxygen saturations) 81% on RA (room air), placed resident on 2L O2 NC (oxygen nasal cannula), then rechecked SaO2: 92-95%, no c/o chest pains noted, [Practitioner] ordered CXR (chest Xray) and Duonebs (breathing treatments) Q4PRN (every 4 hours as needed), [Laboratory] also called and gave lab result for Hgbof (sic) 7.7. Communicated that to [Practitioner] on [communication portal]. Waiting for response. No documentation to show the low hemoglobin of 7.7 was acknowledged/addressed. Review of a Nursing Skilled Care Note dated [DATE] at 12:19 AM for R13 revealed no edema, oxygen saturation of 94% via nasal cannula (no liters of oxygen documented), no shortness of breath. res makes needs known. Cont (continue) B&B (sic). Uses urinal at bedside. Con't (continue) on IV (intravenous) abx (antibiotics)for bacteremia/UTI (urinary tract infection). Review of the Laboratory tests collected on [DATE] for R13 at midnight, the night before he passed away, was received by the Laboratory on [DATE] at 1:22 AM, and resulted on [DATE] at 11:05 AM revealed a potassium level of 5.8 (normal 3.5-5.5), BNP 1477.2, HGB 5.5, HCT 18.1%, and neutrophils 85.5%, and CO2 level was 17.0. Review of a Nursing Progress note dated [DATE] at 3:22 PM for R13 revealed a urine specimen was sent to the Hospital lab. Urine was thick, murky, and tan in color. No documentation to show the physician was notified of findings while waiting for results. Review of the Urinalysis dated [DATE] for R13 revealed a positive culture with Citrobacter [NAME], a bacteria and Candida tropicalis, a fungus. This urine culture resulted after R13 passed away. In an interview on [DATE] at 10:07 AM, the DON was asked about the laboratory report on [DATE] that reflected a low HGB and HCT as well as an elevated BNP, the DON reported the Practitioners had direct access to laboratory results and were to address them if needed and give new orders if indicated. The DON reported she would be concerned about those lab values and could not verify if the physicians were notified of the labs and if they were addressed. The DON stated an elevated BNP could mean R13 had fluid overload. The DON verified the Practitioner Progress note dated [DATE] did not show an assessment/plan, only diagnoses. When questioned about another set of labs drawn on [DATE] for R13, the DON could not find any information on who ordered them or why and verified that they resulted on [DATE] after the resident passed away. The DON verified that there was a urinalysis sent to the lab on [DATE] which revealed R13 also had a urinary tract infection (UTI) and the final result (preculture) was at 4:47 PM. The final urine culture did not result until [DATE]. The DON verified that COPD is a different disease process than CHF (congestive heart failure) and verified she could not find any documentation indicating R13 had COPD. Decreased oxygen-carrying capacity. Hemoglobin carries most of the oxygen to tissues. Anemia and inhalation of toxic substances decrease the oxygen-carrying capacity of blood by reducing the amount of available hemoglobin to transport oxygen. Anemia (e.g., a lower-than-normal hemoglobin level) is a result of decreased hemoglobin production, increased red blood cell destruction, and/or blood loss. Patients (continued on next page)

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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 - Actual harm Residents Affected - Few	have fatigue, decreased activity tolerance, increased breathlessness, increased heart rate, and pallor (especially seen in the conjunctiva of the eye). Oxygenation decreases as a secondary effect with anemia. [NAME], P.ˆA., [NAME], A.ˆG., Stockert, P.ˆA., Hall, A., & [NAME], W.ˆR. (2026). Fundamentals of nursing (12th ed.) p.983. Elsevier. Medications- antibioticsReview of the Hospital Transfer of Care Document for R13 with a discharge date of [DATE] revealed:Discharge Instructions: Continue IV (intravenous) antibiotics that were ordered prior to his admission, 2 weeks of abx (antibiotics) from 6/8 (EOT 6/22).-ampicillin 2 g (grams) in sterile water 14.8 ml (milliliters), Infuse 2g over 3 minutes into a venous catheter every 12 (twelve hours. Indications: Enterococcal Bacteremia (blood infection). No cultures provided, this medication was discontinued upon admission. Review of the MAR for R13 revealed Amoxicillin Oral Tablet 500 MG (milligrams), Give 1 tablet by mouth two times a day for bacteremia for 9 Days. Ordered [DATE] and ended on [DATE]. No indication this was equivalent to the IV-ampicillin transfer of care orders and no cultures provided to show the sensitivity to the antibiotic. -Daptomycin-Sodium Chloride (antibiotic) Intravenous (IV) 350-0.9 MG/50 ML (milliliters) every 48 hours for Enterococcus infections for 10 days. Given [DATE], [DATE], and [DATE]. No cultures provided to show the sensitivity to the antibiotic. Review of a Nursing Progress note dated [DATE] at 5:43 AM for R13 revealed: Resident c/o (complains of) SOB (short of breath) at [3:30 AM], VS (vital signs) 127/79 (blood pressure), P (pulse) 103, T (temperature) 99.1, SaO2 (oxygen saturations) 81% on RA (room air), placed resident on 2L O2 NC (oxygen nasal cannula), no c/o chest pains noted, [Practitioner] ordered CXR and Duonebs (breathing treatment) Q4PRN (every 4 hours as needed). No Documentation to show the Duonebs were provided. Review of a Skilled Care Note dated [DATE] at 12:19 AM for R13 revealed no edema, oxygen saturation of 94% via nasal cannula (no liters of oxygen documented), no shortness of breath. res makes needs known. Cont B&B (sic). Uses urinal at bedside. Con't (continue) on IV (intravenous) abx (antibiotics)for bacteremia/UTI (urinary tract infection). Review of a Practitioner Progress note dated [DATE] at 00:00 for R13 revealed: Visit Type: Acute: (not in person visit) . Started daptomycin for ongoing sepsis. He came to the [Facility] s/p (status post) hospitalization for sepsis. The sepsis was caused by a ureteral stone . and came here for rehab. Are you able to obtain RoS findings Yes. But not directly from patient. Steps undertaken to obtain information. Old medical records. Spoke with nursing staff or caregivers. Respiratory Positive: CTA. ENTEROCOCCUS AS THE CAUSE OF DISEASES CLASSIFIED ELSEWHERE: Treating with daptomycin, IV (intravenous) antibiotics. In an interview on [DATE] at 10:00 AM, the DON was questioned about R13's sepsis/bacteremia infection upon admission. The DON could not find any cultures to ensure R13 received the appropriate antibiotics. The DON reported the previous ADON was the Infection Preventionist at the time and could not find anything to show antibiotic stewardship. Medications: MidodrineReview of the Hospital Transfer of Care Document for R13 with a discharge date of [DATE] revealed:Discharge Instructions: .PRN (as needed) Midodrine added for hypotension (low blood pressure). Review of the Hospital Medication List preadmission to the facility printed [DATE] for R13 revealed:-Midodrine (ProAmatine) 10 mg tablet, take 1 tablet by mouth 4 times daily as needed for other (if SBP < 90). Indications: Blood Pressure Drop Upon Standing for diagnoses: Orthostatic hypotension. Documented in writing is scheduled Q6 (every 6 hours). No pharmacy recommendations to reflect the concern of the PRN status verses scheduled. Review of the [DATE] MAR (Medication Administration Record for R13 shows it was SHEDULED 4 times a day and documented as given 15 times with a SBP >90. Review of the Nursing Progress Notes for R13 revealed on [DATE] was the first of several warnings regarding the Midodrine Order. Physician's Order Note: This order is outside of the recommended dose or frequency. Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 10 mg by mouth every 6 hours for hypotension - The frequency of 4 times per day exceeds the usual frequency of 1 to 3 times per day. No indication the physician was notified and addressed this alert. Midodrine: Symptomatic management of refractory orthostatic hypotension in patients whose lives are impaired. Contraindicated in: Urinary retention; Severe organic heart disease; acute renal failure . Use Cautiously in: . Renal impairment (decrease initial dose); Diabetes mellitus, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	visual problems . Adverse Reactions/Side Effects: CV: Supine hypertension . GU (genitourinary): dysuria, urinary urge/retention/frequency. Neuro: paresthesia, anxiety, confusion, head pressure/fullness, headache, nervousness Route/Dosage: PO (oral) Adults: 10 mg three times daily, Renal Impairment PO (Adults) 2.5 mg three times daily. Assessment: Monitor supine and sitting BP (blood pressure) prior to and during therapy. Lab Test Considerations: Monitor renal and hepatic function prior to and periodically during therapy. Implementation: Because midodrine can cause marked increase of supine BP, it should be used in patients whose lives are considerably impaired despite standard clinical care. F.A. [NAME] Company. (2026). [NAME]'s drug guide for nurses (20th ed.) [Mobile app]. Unbound Medicine. https://davisdrugs.unboundmedicine.com/products/davis_drug_guide. Weights/EdemaReview of the Hospital Cardiology Consult dated [DATE] for R13 revealed a weight (wt) of 76.6 kg (kilograms/ 168.52 pounds/Lbs). No goal/ baseline weight acknowledged/established after admission to the facility. Review of the Order Summary for R13 revealed on [DATE] weekly weights were ordered. On [DATE] daily weights in the morning were ordered and to notify the physician if weight gain of 2 or more pounds in 24 hours or 4 or more pounds over 5 days. On [DATE] the daily weights continued with no specific time ordered. Review of R13's weights revealed as follows:[DATE] 187.4 Lbs at 7:28 PM (an 18.9-pound difference since [DATE])No weights from [DATE] until [DATE]/17/25 186.4 Lbs at 12:26 PM[DATE] 187.5 Lbs at 1:01 PM[DATE] 192.0 Lbs at 10:22 AM (a 4.5-pound difference in 24 hours)[DATE] 188.8 Lbs at 9:07 AM[DATE] 190.8 Lbs at 8:50 AM (a 2-pound difference in 24 hours)[DATE] 187.1 Lbs at 6:00 AM[DATE] 187.1 Lbs at 9:55 AMReview of the Nursing Progress notes reveal no indication the Practitioners were aware of the 4.5-pound weight gain on [DATE]. Review of the Medication Administration Record (MAR) R13 revealed on [DATE] Triamterene (diuretic) 50 mg twice a day was ordered for CHF with CKD (chronic kidney disease). No orders for a baseline weight/goal weight. Review of a Nursing Progress note dated [DATE] at 12:06 PM for R13 revealed: Res experienced a weight gain of 2 pounds in a 24-hour period. Increased edema to BLE (bilateral lower extremities). Currently receives Triamterene oral capsule 50mg BID. Notified on-call provider [Name] of change. Provider states that resident will be added to the rounding schedule for a provider to visit on Monday [DATE]. No changes at this time. Resident comfortable with no s/s of pain, discomfort, or dyspnea. No correlating Nursing Assessment done to reflect the grading assessment of edema. Review of the Skilled Care Notes for R13 dated [DATE] and [DATE] revealed no edema documented. Edema is present when areas of the skin become swollen or edematous from a buildup of fluid in the tissues. Direct trauma and impairment of venous return are two common causes of edema. Inspect edematous areas for location, color, and shape. Edematous skin also appears stretched and shiny. When pressure from the examiner's fingers leaves an indentation in the edematous area, it is called pitting edema. To assess the degree of pitting edema, press the edematous area firmly with the thumb for several seconds and release. The depth of pitting, documented in millimeters, determines the degree of edema (Ball et al., 2023). [NAME], P.ˆA., [NAME], A.ˆG., Stockert, P.ˆA., Hall, A., & [NAME], W.ˆR. (2026). Fundamentals of nursing (12th ed.) p.567. Elsevier. Oxygen/respiratory treatmentsReview of the Order Summary for R13 revealed no orders for a CPAP machine. Review of a Practitioner Telehealth Encounter dated [DATE] at 00:00 for R13 revealed: Nursing originally reported resident was complaining of shortness of air with O2 (oxygen) on room air at 81% (normal is 95-100%), temp 99.1, with improvement in SOA (sic) to 94-95%. Orders given for CXR (chest x-ray) and duoneb (breathing treatment) [every 4 hours as needed].Review of a Nursing Progress note dated [DATE] at 5:43 AM for R13 revealed: Resident c/o (complains of) SOB (short of breath) at [3:30 AM], VS (vital signs) 127/79 (blood pressure), P (pulse) 103, T (temperature) 99.1, SaO2 (oxygen saturations) 81% on RA (room air), placed resident on 2L O2 NC (oxygen nasal cannula), no c/o chest pains noted, [Practitioner] ordered CXR and Duonebs Q4PRN (every 4 hours as needed), [Laboratory] also called and gave lab result for Hgbof (sic) 7.7. Communicated that to [Practitioner] on [communication portal]. Waiting for response. No (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	documentation to show a Practitioner acknowledged concerns or the laboratory values.Review of a Chest X-Ray result dated [DATE] for R13 revealed Mild opacities at both lower bases may represent infiltrates/atelectasis.Review of a LATE ENTRY Practitioner Progress note for R13 ENTERED on [DATE] to reflect the date of [DATE] at 8:00 AM for R13 revealed: Telehealth: Situation: CXR ordered due to oxygen needed since yesterday resulted: Mild opacities at both lung bases may represent infiltrates/atelectasis. Per Nurse, Mild Inspiratory wheeze to left upper lung field noted. Treatment: Continue oxygen therapy as needed. This progress note was entered 4 months after R13 passed away. Review of the MAR for R13 revealed the following orders:-Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML (nebulizer breathing treatment), 3 ml inhale orally every 4 hours as needed for SOB (shortness of breath) or wheezing via nebulizer. Ordered [DATE] and not given until [DATE] at 1:00 AM. -Oxygen, 2 Liters (L) nasal cannula related to low SaO2 (arterial oxygen saturation). Ordered [DATE] and discontinued on [DATE]. -Oxygen, 2 Liters (L) nasal cannula every night and as needed for spO2 (saturation of peripheral oxygen) <90. Every night shift for dyspnea (shortness of breath). Ordered [DATE]. Review of a Practitioner Progress note dated [DATE] at 00:00 for R13 revealed: Visit Type: Acute: (not an in person visit) . Started daptomycin for ongoing sepsis. He came to the [Facility] s/p (status post) hospitalization for sepsis. The sepsis was caused by a ureteral stone . and came here for rehab. Are you able to obtain RoS findings Yes. But not directly from patient. Steps undertaken to obtain information. Old medical records. Spoke with nursing staff or caregiversREVIEW OF SYSTEMS: Are you able to obtain RoS? Yes. But not directly from patient. Steps undertaken to obtain information: Old medical records. Spoke with nursing staff or caregivers. Cardiovascular Positive: Swelling. Positive: Back Pain, Joint Pain or Swelling. Positive: weakness. Weight 186.4 lbs . Respiratory Positive: CTA. ENTEROCOCCUS AS THE CAUSE OF DISEASES CLASSIFIED ELSEWHERE: Treating with daptomycin, IV (intravenous) antibiotics. No acknowledgement of weight difference from preadmission weight. Review of a Skilled Care Note dated [DATE] at 12:19 AM for R13 revealed no edema, oxygen saturation of 94% via nasal cannula (no liters of oxygen documented), no shortness of breath. res makes needs known. Cont B&B (sic). Uses urinal at bedside. Con't (continue) on IV (intravenous) abx (antibiotics)for bacteremia/UTI (urinary tract infection). Review of a LATE ENTRY Nursing Progress noted ENTERED [DATE] at 10:49 AM for R13 with an EFFECTIVE DATE of [DATE] at 1:45 AM (Not the early morning of [DATE]) revealed: Res. c/o (complained of) SOB (shortness of breath), LS (lung sounds) clear and diminished in bases, SpO2 (blood oxygen) tanging between 92% and 95% with O2 at 2LPM NC (liters per minute-nasal canula). PRN Neb tx given as ordered. Post neb tx Res. States feeling better. HOB (head of bed) elevated, Res. Encouraged to exhale with pursed lips (the way a COPD patient would breathe), CPAP on with O2 NC (indicating the CPAP was placed over the NC). Review of a LATE ENTRY Nursing Progress note entered [DATE] at 10:57 AM for R13 and back dated for [DATE] at 4:45 AM revealed: Res. Observed in bed resting quietly by this nurse. CPAP on with O2. Res. Gave a thumbs up and said I'm good to go HOB elevated, call light in reach. Review of a LATE ENTRY Nursing Progress note ENTERED [DATE] at 11:43 AM for R13, back dated to [DATE] at 8:00 AM revealed: At approximately 0500, this nurse called to room [ROOM NUMBER] d/t Res. observed by CNA not breathing. Approx. 0502- CODE BLUE paged via intercom.Upon entering room with AED and Crash cart, Res. observed in bed absent of HR or Respirations. Chest compressions immediately started by this Nurse. CNA instructed to activate EMS. 2nd night Nurse XX entered room to assist with CPR. Res. transferred to floor for more effective CPR measures. AED pads applied to Res. Bare chest, shock was not advised, CPR continued. Code status documentation reviewed and code status is DNR. A copy of the advance directive handed to MDS, CPR halted . In an interview on [DATE] at 11:36 AM, RN K (former employee) reported the night of [DATE], that R13 was stable for his condition and that he checked on R13 frequently. He stated that R13's vital signs were good when he checked them, and R13 even gave him a thumbs up. RN K reported that R13's lungs were diminished but his pulse and oxygen saturations were good for him. He stated that R13 was a smoker and a COPD patient with ongoing (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	difficulty breathing. RN K reported that he had problems documenting in the Electronic Medical Record (EMR) that night ([DATE]-[DATE]) because his notes would not save. He stated that R13 did not have any changes in condition during his shift and appeared the same as when he started his shift. He also said he was told during shift report that R13 had gone out to the hospital and returned, had labs drawn, and that lab results were pending, but he could not recall the details. RN K reported that he was told the Nurse Practitioner had seen R13 earlier that day. RN K could not recall whether there was an order for CPAP machine (Continuous Positive Airway Pressure to treat sleep apnea). He reported that he was not aware of R13's elevated BNP level or low HGB level. When asked what an elevated BNP indicated, RN K stated that it could suggest potential volume overload. No documentation in the EMR indicated R13 went out to the hospital and no documentation to indicate the Practitioner visited R13. Review of an Advance Directive document signed by R13 on [DATE] and by the physician on [DATE] revealed R13 requested no CPR. Review of the Order Summary in the EMR for R13 revealed the resident was documented as being a Full Code. In an interview on [DATE] at 10:00 AM, the DON was questioned about R13's oxygen and lack of CPAP orders, the DON reported there should have been an order for the CPAP from the physician and if there was an order, the resident's nasal cannula should have been removed so the CPAP could have a better seal for oxygen delivery. Any refusals should be documented then. Continuous positive airway pressure (CPCP) maintains a steady stream of pressure throughout a patient's breathing cycle. It benefits patients with obstructive sleep apnea (OSA), patients with heart failure, . Equipment includes a mask that fits over the nose or both nose and mouth and a CPAP machine that delivers air to the mask. The smallest mask with the proper fit is the most effective. It must be tight enough to form a seal on the face so that the air does not escape but not so tight as to cause pressure injury formation or necrosis where the mask is against the face. [NAME], P.ˆA., [NAME], A.ˆG., Stockert, P.ˆA., Hall, A., & [NAME], W.ˆR. (2026). Fundamentals of nursing (12th ed.) p. 1007-1008. Elsevier. PainReview of the Transfer of Care orders dated [DATE] for R13 revealed: .Tamsulosin 0.4 mg daily is given to help with STENT spasms. You can start using ibuprofen 800 mg three times a day starting from the day, if the two medications above are not enough you can CALL TO GET Oxycodone. You can take Pyridium for burning when you pee. Review of the [DATE] MAR for R13 revealed the following orders:_Acetaminophen 500 MG tablet every 8 hours as needed for pain for 7 days ordered [DATE] and discontinued [DATE]. Not one dose was documented as given and does not address what pain this order was for. -Acetaminophen 500 MG tablet every 8 hours as needed for pain for pain/fever. Ordered [DATE] and discontinued [DATE]. Not one dose was documented as given and did not address what pain this was for. - Hydrocodone-Acetaminophen Tablet 5-325 MG (Hydrocodone-Acetaminophen), Give 1 tablet by mouth every 6 hours as needed for pain. Ordered [DATE]. Given [DATE] at 1:00 PM for a pain level of 2. No documentation to reflect where the pain was and the order does not address what pain this was for. Review of a Practitioner Progress note dated [DATE] at 00:00 for R13 revealed: Telehealth: Nurse reports patient has been exhibiting increased pain. Has order for Norco (opioid), needs script. Short script of Norco sent. Rounding team notified. No pain assessment available or information regarding where the pain was or why Tylenol was not given first. Review of a Nursing Skilled Care Note dated [DATE] at 10:23 AM for R13 revealed a pain assessment is documented as no pain. Examine Results: Evaluation occurs every time you have contact with a patient. It is an ongoing process that includes a comparison of before and after an intervention or a comparison with an established standard after an intervention. Once you deliver an intervention, you continuously examine results by gathering subjective and objective data from a patient, family, and health care team members (as appropriate). At the same time, you reflect on your knowledge regarding a patient's current condition, the treatment, and the resources available for recovery. [NAME], P.ˆA., [NAME], A.ˆG., Stockert, P.ˆA., Hall, A., & [NAME], W.ˆR. (2026). Fundamentals of nursing (12th ed.) p. 296. Elsevier. Care Plans:Review of the Care Plan for R13 revealed the following: Special Instructions: Meds: Whole admitted here for short term rehab following (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	hospitalization for UTI. He also has CAD, CHF, HTN, DM, sleep Apnea and Anemia. PLEASE document on s/s's of UTI, pain, safety awareness, ability to compete ADL's and participation in therapy. TELEMED CONSENT [DATE].- Need: (R13) is at risk for cardiac complications related to multiple cardiovascular diseases: CAD (coronary artery disease), HTN (hypertension), Afib (atrial fibrillation), initiated on [DATE] and revised on [DATE]. Review of the Care Plan for R13 revealed:- Need: (R13) is at risk for pain. He generally denies any discomfort. Initiated [DATE]. Interventions included: Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Does not address acute verses chronic pain or the location of pain. No Care Plan with a CHF focus on interventions, no bacteremia/sepsis Care Plans, or Advance Directives. R1Review of R1's admission Record dated [DATE] revealed she was admitted to the facility on [DATE] and had diagnoses that included: Frontotemporal neurocognitive disorder, drug induced subacute dyskinesia (neurological disorder characterized by involuntary, repetitive, and purposeless muscle movement), and person history of traumatic brain injury. R1 was her own responsible party.Review of R1's Brief Interview of Mental Status (BIMS), dated [DATE] revealed she scored 15/15 (normal cognition).Review of a police report dated [DATE] at 12:11 PM revealed the police responded to the facility at on [DATE] at 12:19 PM and spoke with R1's Advocate AA, the DON (Director of Nursing) and the NHA (Nursing Home Administrator). The fire department and an ambulance service were already at the facility and R1 was transported to the hospital. The police office spoke to R1's Advocate AA. Name of AA reported that (name of R1) was supposed to receive her medications at 0700 hours, 1200 hours and 1900 hours. (Name of R1) had told AA she did not get her medication until 10:00 AM. Today at 1200 hours (Name of R1) was offered her noon medication, but she refused because she would be taking them too close. When (Name of R1) refused to take the medications facility staff stated they would deny the medication for her in the future, so (name of R1) took the medication. The DON was interviewed and confirmed R1 was supposed take her medications at 7:00 AM but she was sleeping at that time, and the nurse did not make it back to give her here 7:00 AM medications until 10:08 AM. R1 demanded her medications again at 12:00 PM and because R1 was demanding her medications the nurse allowed R1 to take her medications. The DON stated, the medication ClonazePAM would never put (name of R1) in a medical emergency. According to (name of DON), (name of R1) had been scheduled to take one ClonazePAM in the morning, one ClonazePAM in the afternoon, and three ClonazePAM in the evening. (Name of DON) stated (name of R1) would've supposedly overdosed every night if she had taken the medications like how she should've since (name of R1) scheduled to take 3 ClonazePAM in the evening and (name of R1) only took two today. After actions, revealed, With the accusations of potentially having (name of R1) overdose on her medications, I submitted a report to Michigan [NAME] (Licensing and Regulatory Affairs).Review of R1's Hospital admission (discharged) report dated [DATE] revealed R1 went to the Emergency Department on [DATE] with a chief complaint of Altered Mental Status Pt (patient) resides at nursing facility, received an extra dose of Clonazepam at 12:30, normally oriented X4: GCS Glasgow Coma Scale (tool used to score a person's level of consciousness) of 14. A score of 13-15 indicates mild to minor brain injury/altered consciousness. Review of Medical Decision Making revealed, Suspect this behavior and extension of her conversion disorder more behavioral. Vital signs were stable. Her friend was quite pressuring about her getting her meds on a regular schedule but she is on Zanaflex with gabapentin and other meds that would alter her

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The Laurels of Hudsonville	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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. This citation pertains to intakes 2794208 Based on interview and record review, the facility failed to ensure all nursing staff and nursing aides received competency training upon hire/annually. This deficient practice affects all 86 residents who reside in the facility. Findings Include: Review of 6 employee files that included 3 nurses and 3 certified nursing assistants (CNAs), revealed none of the six had skills checks completed upon hire and/or annual skills checks. Of the employee files reviewed, only one nurse was still employed at the time of this review. In an interview on 5/28/26 at 8:54 AM, the Human Resource Manager (HR) Q verified that the 6 employee files reviewed did not contain completed competency skills checks. When asked about whether the current staff had completed competencies, HR Q stated that the previous DON had not completed any competencies either, and they were trying to develop a system to ensure completion. The new Assistant Director of Nursing (ADON), who had been at the facility for only 2-3 months, would be working on this. HR Q confirmed that no current employees had verified competencies in their files.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2794208. Based on interview and record review, the facility failed to ensure the appropriate antibiotic was implemented for one (R13) of one resident reviewed for antibiotics. Findings include Review of a Face Sheet revealed R13 admitted to the facility on [DATE] with pertinent diagnoses of congestive heart failure, cognitive communication deficit, cardiomyopathy, enterococcus (bacterial infection) unspecified, and diabetes (as listed for primary admission). Review of the Hospital Transfer of Care Document for R13 with a discharge date of 6/13/25 revealed:Discharge Instructions: Continue IV (intravenous) antibiotics that were ordered prior to his admission, 2 weeks of abx (antibiotics) from 6/8 (EOT 6/22).-ampicillin 2 g (grams) in sterile water 14.8 ml (milliliters), Infuse 2g over 3 minutes into a venous catheter every 12 (twelve hours. Indications: Enterococcal Bacteremia (blood infection). (No cultures provided and was discontinued upon admission to the Facility.) Review of the MAR for R13 revealed Amoxicillin Oral Tablet 500 MG (milligrams), Give 1 tablet by mouth two times a day for bacteremia for 9 Days. Ordered 6/13/25 and ended on 6/22/25. No indication this was equivalent to the IV ampicillin per the transfer of care orders and no cultures provided to show the sensitivity to the antibiotic which would indicate the appropriateness. -Daptomycin-Sodium Chloride (antibiotic) Intravenous (IV) 350-0.9 MG/50 ML (milliliters) every 48 hours for Enterococcus infections for 10 days. Given 6/18/25, 6/20/25, and 6/22/25. No cultures to show the sensitivity to the antibiotic which would indicate the appropriateness.Review of the Laboratory tests collected on 6/16/25 for R13 revealed: .neutrophils 82.1% (normal 43.4 - 76.2, indicating an infection). No documentation indicating the practitioner acknowledged the abnormal lab values. Review of a Practitioner Progress note dated 6/18/25 at 00:00 for R13 revealed: Visit Type: Acute: . Started daptomycin for ongoing sepsis. He came to the [Facility] s/p (status post) hospitalization for sepsis. The sepsis was caused by a ureteral stone . and came here for rehab. Are you able to obtain RoS (sic) findings Yes. But not directly from patient. Steps undertaken to obtain information. Old medical records. Spoke with nursing staff or caregiversRespiratory Positive: CTA. ENTEROCOCCUS AS THE CAUSE OF DISEASES CLASSIFIED ELSEWHERE: Treating with daptomycin, IV (intravenous) antibiotics. Review of a Skilled Care Note dated 6/21/25 at 12:19 AM for R13 revealed: Con't (continue) on IV (intravenous) abx (antibiotics)for bacteremia/UTI (urinary tract infection). Review of a Nursing Progress note dated 6/23/25 at 3:22 PM for R13 revealed a urine specimen was sent to the Hospital lab. Urine was thick, murky, and tan in color. No documentation to show the physician was notified of the findings before the urine specimen was sent out. Review of the Urinalysis dated 6/23/25 for R13 revealed a positive culture with Citrobacter [NAME] bacteria and Candida tropicalis, a fungus. In an interview on 6/1/26 at 10:00 AM, the DON was questioned about R13's sepsis/bacteremia infection upon admission. The DON could not find any cultures to verify and ensure R13 received the appropriate antibiotics. The DON reported that the previous ADON was the Infection Preventionist at the time and could not find anything to show antibiotic stewardship for R13 to ensure his antibiotics were appropriate.