STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46999 This citation contains 2 Deficiency Practice Statements, DPS #1 and #2. This citation pertains to intake number MI00142844 DPS#1 Based on interviews, and record review, the facility failed to protect the resident's right to be free from resident to resident verbal and physical abuse for 1 (Resident #100) of 4 Residents reviewed for abuse, resulting in Resident #100 experiencing fear, increased agitation, and requiring inpatient psychiatric hospitalization . Findings include: Review of an Admission Record with a reference date of 11/24/23 revealed Resident #100 was admitted to the facility with pertinent diagnoses that included: anxiety disorder, repeated falls, altered mental status, major depressive disorder. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 11/30/23 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #100 was severely cognitively impaired. Review of a Care Plan for Resident # 100, with a reference date of 12/11/23, revealed a focus/goal/interventions of: (Resident #100) has the potential for fluctuations in mood related to depression . anxiety. Goal: Mood will have minimal effect of daily life .Interventions .approach in calm, quiet manner . report changes in mood . Review of an Incident Report with a reference date of 1/15/24 revealed Resident #100 was found injured, laying on his bathroom floor at 1:30am. At that time, Resident #100 reported a man pushed him down. Resident #102, who shared the bathroom with Resident #100 but lived in the adjoining suite, reported he pushed Resident #100 because the resident exited the bathroom and entered his suite. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 3/19/24 at 1:12pm Competency Evaluated Nursing Assistant (CENA) M reported she cared for Resident #100 regularly prior to the incident on 1/15/24. CENA M reported Resident #100 was very sensitive to his environment and became very stressed by loud noises. CENA M reported she witnessed Resident #102 becoming verbally aggressive, yelling at Resident #100 several times and she made a point to provide Resident #100 with scheduled toileting assistance to decrease the likelihood of the resident attempting to go to the bathroom alone, and accidentally entering Resident #102's room. CENA M reported prior to the incident on 1/15/24 she could successfully assist Resident #100 with cares without him experiencing agitation, but after the incident he was not directable. In an interview on 3/19/24 at 10:16am, Licensed Practical Nurse (LPN) J reported she found Resident #100 on his bathroom floor at approximately 1:30am on 1/15/24. LPN J reported she began evaluating Resident #100 as he laid on the floor and he told her someone pushed him down. At that point, Resident #102 (Resident #100's suite mate), entered the bathroom and yelled I pushed him. Resident #102 said to Resident #100, You know why I pushed you. You kept coming in my room!. Resident #102 left the bathroom and slammed the door. When queried about Resident #100's injuries from the assault, LPN J reported Resident #100 had a hematoma on his forehead and complained of pain in his right elbow. LPN J reported she observed Resident #102 yelling at Resident #100 many times in the past when Resident #100 mistakenly entered Resident #102's room. LPN J reported Resident #102 used a loud, angry tone of voice during these interactions. In an interview on 3/20/24 at 9:03am, Competency Evaluated Nursing Assistant (CENA) L reported she heard a loud thud at approximately 1:30am on 1/15/24 and when she responded to the noise, she saw Resident #100 laying on his bathroom floor, LPN J was already present. CENA L reported she assisted Resident #100 off the floor, assisted him with toileting and then escorted him to a common area. CENA L reported Resident #100 appeared fearful and was visibly emotionally shaken up. As CENA L sat with Resident #100 he stated Why did that happen? We have to get along. CENA L reported Resident #100 complained of pain on his right side. Review of a Nurses Note entered at 4:40pm with a reference date of 1/15/24 revealed Resident #100 was evaluated with neuro checks (assessment of mental status, level of consciousness, pupillary response, motor strength, sensation, and gait) after the physical altercation and was sent to a local emergency department for further evaluation after he developed tremors and worsening balance. In an interview on 3/19/24 at 3:37pm, Competency Evaluated Nursing Assistant (CENA) D reported she witnessed Resident #102 yelling at Resident #100 many times prior to the incident that involved the physical altercation. CENA D reported Resident #100 took himself to the bathroom frequently but when he did so, he often mistakenly exited through the door that led directly into Resident #102's room. CENA D reported Resident #102 had threatened to hit Resident #100 and as a result, Resident #100 appeared scared to enter the bathroom he shared with Resident #102. In an interview on 3/20/24 at 11:34am Competency Evaluated Nursing Assistant (CENA) R reported she witnessed Resident #102 yelling at Resident #100 numerous times after Resident #100 mistakenly entered Resident #102's room from their shared bathroom. CENA R reported Resident #102 made threatening statements, saying he was going to get him. CENA R reported Resident #100 appeared scared to enter the bathroom and the facility should have taken action to resolve the situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 3/19/24 at 12:00pm, Licensed Practical Nurse (LPN) K reported Resident #102 had been verbally aggressive toward Resident #100 several times, and at one time had threatened to hit him. LPN K reported the facility had considered moving one of the residents to another room after Resident #102 threatened Resident #100, but no room moves had occurred. LPN K reported she cared for Resident #100 when he returned from the emergency room evaluation and at that time, he displayed almost constant symptoms of emotional distress and physical agitation. In an interview on 3/21/24 at 9:14am, Social Services Director (SSD) N she was aware that there was ongoing conflict involving Resident #100 inadvertently entering Resident #102's room, but neither had been offered the opportunity to move to another room until Resident #102 assaulted Resident #100. SSD N denied knowledge of Resident #102 yelling at Resident #100. In an interview on 3/21/24 at 3:30pm Nursing Home Administrator A reported staff were expected to report all potential resident abuse, including verbal or physical abuse immediately. When further queried, NHA A denied any reports of abuse involving Resident #100 prior to the physical assault on 1/15/24. NHA confirmed that verbal threats directed toward a resident and a resident putting hands on another in anger constitute abuse. Review of a History and Physical report from a local hospital revealed Resident #100 was evaluated for a traumatic brain injury, testing was negative, and he returned to the facility. Review of a Nurses Note entered at 6:30pm on 1/16/24 revealed a statement (Resident #100) has become more aggressive since fall on 1/15/24. Review of a Nurses Note entered at 6:00am on 1/17/24 revealed Resident #100 jolted awake, grabbed a staff members shirt and voiced he felt angry. Review of a Nurses Note entered at 5:00pm on 1/17/24 revealed Resident #100 was put on 1:1 supervision due to increased physical restlessness. Review of a Provider's Note with a reference date of 1/17/24 revealed Resident #100 began attempting to hit, push, and grab staff during cares and as a result was referred to an inpatient psychiatric hospital. Review of a Social Services Note entered at 2:51pm on 1/17/24 revealed Resident #100 was accepted for admission at an inpatient psychiatric hospital and left the facility at approximately 5:30pm. Using the reasonable person concept, though Resident #100 had decreased ability to verbally express his own thoughts due to his mental diagnoses, he was clearly fearful and angry following the verbal and physical abuse endured prior to and on 1/15/24. DPS #2 This citation pertains to intake # MI00142845 Based on interviews and record review the facility failed to protect the resident's right to be free from resident to resident physical abuse for 1 (Resident #102) of 4 residents reviewed for abuse, resulting in Resident #102 being punched in the face by another resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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 0600 Level of Harm - Actual harm Residents Affected - Few	Findings include: Review of an Admission Record with a reference date of 3/19/18 revealed Resident #102 was admitted to the facility with pertinent diagnoses that included: unspecified dementia with other behavioral disturbances, cognitive communication deficit, and mood disorder. Review of Minimum Data Set (MDS) assessment with a reference date of 2/26/24 revealed a Brief Inventory for Mental Status (BIMS) score of 5/15 which indicated Resident #102 was severely cognitively impaired. Section E of the MDS revealed Resident #102 had no behaviors directed at others in the last 7 days. Review of an Incident Report with a reference date of 1/20/24 revealed Resident #102 was struck in the face with a closed fist by Resident #101. In an interview on 3/20/24 at 2:18pm, Competency Evaluated Nursing Assistant (CENA) H reported 1/20/24 she heard residents yelling outside the activity room and ran to respond to the situation. CENA H reported as she ran up to the residents, she saw Resident #101 punch Resident #102 in the jaw with a closed fist. Resident #102 raised his arms in a defensive manner at which time Resident #101 struck Resident #102 in the arm with her hand. CENA H reported Resident #102 was visibly emotionally upset by Resident #101's actions and reported he just asked her to stop bumping into his wheelchair, but she got angry and hit him. In an interview on 3/20/24 at 3:56pm Licensed Practical Nurse (LPN) U reported she witnessed incidents in which Resident #101 became verbally and physically aggressive toward other residents, especially in the area outside the activities room. LPN U reported Resident #101 was easily over stimulated when she was in that area and other residents were nearby, as a result the staff tried to keep that area uncrowded and tried to keep Resident #101 away from others. LPN U reported Resident #101 was easily angered when asked to perform any action. In an interview on 3/21/24 at 8:54am, Resident #102 did not recall the altercation that took place on 1/20/24. In an interview on 3/21/24 at 9:42 Social Services Director (SSD) N reported Resident #101 had been physically aggressive toward other residents, primarily in the area outside the activities room. Review of a Behavior Monitoring Log with a reference date of January 2024, revealed Resident #101 demonstrated physically aggressive behavior on 1/16, 1/17, 1/18, 1/19 and 1/20. Review of a Abuse Prohibition policy with a reference date of 9/9/22 revealed a statement Abuse means the willful inflection of injury .intimidation .resulting in physical harm, pain or mental anguish .it includes verbal abuse .physical abuse .and mental abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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 - 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** 46999 This citation pertains to MI00142844 Based on interview and record review the facility failed to initiate appropriate treatment measures for 1(Resident #100) of 4 residents reviewed for quality of care, resulting in a Resident #100 experiencing increased pain, developing an ankle abscess, sepsis, and requiring hospitalization . Findings include: Review of a facility policy titled Notification of Change with a reference date of 2/14/124 revealed: The facility must inform .the resident's practitioner when there is change in status .a change in status would include .a need to alter treatment .or to commence a new form of treatment . Review of an Admission Record with a reference date of 11/24/23 revealed Resident #100 was admitted to the facility with pertinent diagnoses that included: anxiety disorder, repeated falls, altered mental status, pain, and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 11/30/23 revealed a Brief Interview for Mental Status (BIMS) score of 1/15 which indicated Resident #100 was severely cognitively impaired. Section B of the MDS revealed Resident #100 had unclear speech, moderate difficulty hearing, usually made self understood, and sometimes understood what was being said to him. Section M revealed Resident #100 was deemed at risk for developing pressure ulcers/skin injuries. Review of a MDS assessment for Resident #100, with a reference date of 2/8/24 revealed Resident #100 returned to the facility following a hospitalization in a psychiatric hospital. Review of a MDS assessment for Resident #100, with a reference date of 2/21/24 revealed Resident #100 returned to the facility following an admission to a medical hospital. Review of a MDS assessment for Resident #100, with a reference date of 2/29/24, Section M revealed Resident #100 had an infection of the foot, a surgical wound that required wound care, dressings to his feet, started receiving an opioid, and had entered hospice (end of life) care. Review of a Nursing Comprehensive Evaluation dated 2/8/24, section K revealed Resident #100 had an actual impairment to his skin integrity (skin is compromised due to injuries like cuts, rashes, abrasions). The description of Resident #100's locations of impaired skin included: forehead scab, mid back skin tear, bilateral upper extremity discoloration, right lower extremity skin tear, left lower extremity scabs. Review of physician orders for Resident #100 with a reference date of 2/8-2/21/24 revealed no orders related to the treatment of skin tears or wounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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 - Actual harm Residents Affected - Few	In an interview on 3/19/24 at 12:47pm Licensed Practical Nurse (LPN) J reported she completed the skin assessment portion of the comprehensive nursing evaluation for Resident #100 on 2/8/24. LPN J reported Resident #100 was readmitted that day with 4 skin integrity concerns, including a skin tear on his right lower leg. LPN J reported when a resident was admitted with a skin integrity concern, the Unit Manager would typically reach out to the physician for treatment orders. LPN J reported the facility no longer had a Unit Manager and as a result, getting treatment orders for Resident #100's skin issues slipped through the cracks. LPN J reported she wrapped Resident #100's wound in gauze but it did not stay in place. LPN J reported she did not reach out to the provider for treatment orders for Resident #100's skin tears. In an interview on 3/21/24 at 8:53am Licensed Practical Nurse (LPN) Q reported it was the responsibility of the nurse to notify the provider if a resident was admitted with a skin issue and there were no treatment orders in place. LPN Q reported if a skin tear was not properly cared for, there was potential for the injury to worsen and become infected. In an interview on 3/19/24 at 2:40pm LPN V reported if a resident was admitted with a skin tear the nurse should alert the provider and seek orders for treatment of the skin tear. Review of a Treatment Administration Record for Resident #100 revealed no orders for wound care until 2/22/24. In an interview on 3/20/24 at 11:23am, Wound Care Physician (MD) T reported he only evaluated residents when alerted by the nursing staff and had not evaluated Resident #100. MD T reported a skin tear required therapeutic intervention to avoid worsening of the injury and to reduce the potential for infection. MD T reported a nurse should contact the provider to seek orders for care of skin tears. When further queried, MD T reported if a resident developed a swollen, painful, reddened area with a loss of function, the nurse should contact the physician to rule out an infection. In an interview on 3/19/24 at 1:12pm, Competency Evaluated Nursing Assistant (CENA) P reported she knew Resident #100 well and noticed his right lower leg was swollen upon his return to the facility on [DATE]. CENA P reported Resident #100 winced in pain when she attempted to don a nonskid sock on his right foot. CENA P reported in the days prior to Resident #100 being hospitalized on [DATE], his oral intake was very poor and his functional abilities declined significantly. Review of an Amount Eaten record for Resident #100 revealed the resident did not eat on 2/10, 2/11, 2/12, 2/13 or 2/14/24. In an interview on 3/19/24 at 3:37pm, CENA D reported she noticed Resident #100's right leg was swollen when she cared for him on 2/9/24. CENA D reported when she touched the resident's leg he verbalized ouch! and she reported his complaint of pain to the nurse. CENA D reported Resident #100 was normally not painful. Review of a Pain level record for Resident #100 revealed his pain level was assessed at 0 on scale of 0-10 when he readmitted to the facility on [DATE]. On 2/11/24, Resident #100's pain level was assessed as a 3. On 2/13/24 Resident #100's pain level was assessed as a 4. On 2/14/24 Resident #100's pain level was assessed as an 8 on a scale of 0-10. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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 - Actual harm Residents Affected - Few	In an interview on 3/20/24 at 9:03am, Competency Evaluated Nursing Assistant (CENA) R reported Resident #100 returned to the facility from an inpatient psychiatric hospitalization and at that time his leg appeared swollen. CENA R noticed that Resident #100 was primarily using a wheelchair and had previously been able to walk. CENA R reported she became concerned with the appearance of Resident #100's right lower leg, noticed a darkened area appeared on his foot, the swelling continued to worsen, then a wound opened and began draining. CENA R reported a nurse applied gauze around the resident's leg, but it did not stay on. In an interview on 3/20/24 at 3:37pm CENA O reported Resident #100 was not himself when he returned to the facility on [DATE]. CENA O reported Resident #100 was not walking well, his right lower leg was swollen, and he was not able to verbalize his thoughts. In an interview on 3/20/24 at 11:23am LPN C reported she worked on 2/9/24 was assigned to Resident #100's memory care unit but also to another area of the facility and it was hard to keep track of the resident's needs in memory care that day. LPN C did report Resident #100 had swelling in his right lower leg and would not allow anyone to touch it. LPN C reported she was not aware Resident #100 had skin tears and if he had treatments scheduled, they were not on her shift. LPN C was the nurse for Resident #100's unit on 2/10 and 2/11/24 as well. In an interview on 3/21/24 at 8:06am, LPN W reported a CENA asked her to come see Resident #100's ankle on 3/13/24. LPN W she looked at Resident #100's right lower leg, noted it was bright red, extremely swollen and appeared as though the skin was going to open around the area of his ankle. When queried about the appearance of Resident #100's leg, LPN W described it as festering as though it was infected. LPN W reported she asked Resident #100's nurse to evaluate his leg. No documentation of further evaluation was present. In an interview on 3/21/24 at 10:28am, Nurse Practitioner (NP) S reported she was usually made aware of skin tears and other skin conditions by the floor nurses. NP S reported to her knowledge, Resident #100 did not have a skin tear on his right lower leg, and she was unsure when he developed the wound on his ankle. When further queried about an appropriate course of treatment for a resident who developed redness, swelling, pain in an area near a skin tear, NP S reported she would start an antibiotic and order laboratory testing to evaluate for an infection. In an interview on 3/20/24 at 1:06pm, LPN K reported she was shocked at the appearance of Resident #100's right lower leg when she returned to work on 2/13/24. LPN K reported his leg was swollen, very red and she noticed a small blister forming that looked like an insect bite. LPN K reached out to the provider and an ultrasound was ordered to rule out a deep vein thrombosis (blood clot). LPN K reported by 2/14/24, Resident #100 had a large draining wound on his ankle, and she received orders to have the resident transferred to the hospital. The ultrasound was not completed prior to Resident #100 being admitted to the hospital on 2/14/24. Review of the Orthopedic Hospital Consult for Resident #100 dated 2/14/24 revealed, RLE (right lower extremity): Edema and erythema throughout the foot and ankle, Large bullous appearing lesion, approximately 10 cm, centered over the lateral malleolus, no active drainage; lesion is fluctuant with surrounding induration, A more proximal 4 cm lesion is present on the lateral aspect of the lower leg with overlying eschar, mild surrounding erythema, no active drainage or bleeding, no associated fluctuance. Patient withdrawing and kicking leg with any attempted exam, unable to thoroughly assess for subcutaneous emphysema. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235483	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Galesburg (the)	1080 N 35th Street Galesburg, MI 49053

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 - Actual harm Residents Affected - Few	Review of a medical record revealed Resident #100 was admitted to a local medical hospital on 2/14/24 with pertinent diagnoses that included: sepsis from the skin and soft tissue of the ankle (serious condition resulting from the microorganisms in the blood or other tissues, potentially leading to malfunctioning of various organs, shock, and death), right ankle abscess, acute kidney injury, and acute toxic metabolic encephalopathy. Resident #100's white blood cell (WBC) count was 48.6 (normal 4.0-11.0) Further review revealed Resident #100 underwent 4 surgical interventions of his right foot/ankle, resulting in a wound that measured 13cm x 11cm. Resident #100 was discharged back to the facility on [DATE] on hospice. Review of the facility's Skin Management policy with a reference date of 12/15/22 revealed under a section titled Practice Guidelines: upon admission/re-admission all residents are evaluated for skin integrity . residents admitted with any skin impairment will have physician's orders for treatment .if a new skin impairment is identified .notify physician . The section titled Treatment of Skin Tears revealed: .all skin tears will be .treated based on physician's orders.