

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Laurels of Galesburg (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999</p> <p>This citation pertains to intake number MI00147366.</p> <p>Based on interview and record review, the facility failed to ensure 3 (Resident #101, Resident #102, and Resident #103) of 3 residents reviewed for dementia care, were treated in a manner that supported their psychosocial wellness, resulting in the residents experiencing avoidable stress responses to care interventions.</p> <p>Findings include:</p> <p>Review of The Unmet Needs Model, [NAME]-[NAME] and [NAME] (1995), revealed that those with dementia develop problem behaviors from an imbalance in the interaction between life-long habits and personality, current physical and mental states and less than optimal environmental conditions.</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia with agitation, difficulty walking, bipolar disorder (mental health condition that causes extreme mood swings), and generalized anxiety disorder (mental health condition characterized by persistent anxiety).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 10/25/24 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #101 was cognitively impaired.</p> <p>Review of a Care Plan for Resident #101, with a reference date of 4/30/24, revealed a need/goal/interventions of: (Resident #101) has the potential for fluctuations in mood R/T (related to) Dx (diagnosis) of dementia, Goal: (Resident #101) will have stable or improved mood state goal (sic) to be happier, have calmer appearance .Interventions: approach in a calm, quiet manner. Maintain appropriate body language during interactions such as maintaining eye contact and sitting in a relaxed position.</p> <p>Review of an Incident Investigation Report dated 9/14/24 revealed it was reported that Licensed Practical Nurse (LPN) D was witnessed yelling at Resident #101.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/18/24, at 12:08pm, Certified Nursing Assistant (CNA) H reported on 9/14/24 she witnessed LPN D storm into Resident #101's room as the resident sat on her bed and undressed herself. CNA H reported she heard LPN D say to Resident #101, in an emotionally charged tone, What are you doing with your clothes off?. CNA H reported Resident #101 became agitated and stood up abruptly after LPN D spoke to her rudely and began walking toward the doorway in an unsafe manner with a blanket wrapped around her, partially dragging the blanket on the floor by her feet. CNA H reported prior to the interaction with LPN D Resident #101 was calm and safe as she sat on her bed and fidgeted with her clothing.</p> <p>In an interview on 12/19/24, at 9:10am, CNA F reported on 9/14/24, as she walked down the hall toward Resident #101's room, she heard LPN D speaking harshly in Resident #101's room, as she stated, You know you shouldn't be doing that. CNA F reported Resident #101 walked into the hallway abruptly, appeared angry, and stated, I want that b**** out of my room, referring to LPN D. CNA F reported prior to the incident with LPN D, she observed Resident #101 sitting calmly on her bed, making repetitive movements with her clothing and because it was nighttime, no one else was around so it was not a concern regarding her dignity.</p> <p>In an interview on 12/19/24 at 11:38am, Family Member N reported Resident #101 valued feeling treated respectfully by others and would become upset if she felt she was being mistreated. FM N reported, as long she felt you were treating her well, she'd do anything for others and was a kind person.</p> <p>In an interview on 12/19/24, at 12:53pm, LPN D reported she tried to intervene when she saw Resident #101 disrobing in her room but the resident didn't want to listen and became increasingly frustrated as LPN D attempted to redirect her repeatedly. LPN D reported prior to this incident, the only dementia care training she received was computer based. LPN D reported she was told she would receive additional specialized dementia care training but had not been given the opportunity to do so, and she believed it had fallen through the cracks with the change in management. LPN D reported after Resident #101's negative response to her attempt to intervene, she learned that the resident only became more agitated with her attempts. LPN D stated I learned now not to keep telling her not to do something because she only gets more and more upset.</p> <p>In an interview on 12/19/24, at 1:59pm, Resident #101 could not recall the incident that took place on 9/14/24.</p> <p>Resident #102</p> <p>Review of an Admission Record revealed Resident #102, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia with behavioral disturbance, schizoaffective disorder/bipolar type (type of schizophrenia which features bouts of mania and depression), major depressive disorder (persistent feelings of sadness and low mood), and generalized anxiety disorder (mental health condition characterized by persistent anxiety).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 11/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #102 was cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Care Plan for Resident # 102, with a reference date of 2/1/24, revealed a need/goal/interventions of: (Resident #102) has the potential for fluctuations in mood R/T (related to) dementia, bipolar disorder, major depression, anxiety, insomnia, schizoaffective disorder. Goal: Mood will have minimal effects of daily life .Interventions: Approach in calm, quiet manner. Maintain appropriate body language during interactions .</p> <p>Review of an Incident Investigation Report dated 9/14/24 revealed it was reported that Licensed Practical Nurse (LPN) D was witnessed yelling at Resident #102.</p> <p>In an interview on 12/18/24, at 11:36am, CNA J reported LPN D appeared stressed and stated, Welcome to hell, when CNA J arrived on the memory care unit on the morning of 9/14/24. CNA J reported as staff stood at the nurse's station, Resident #102 was next to the nurse's station in her wheelchair. CNA J reported she was unsure what happened between Resident #102 and LPN D but she saw LPN D get in Resident #102's face and yell at her. CNA J reported she did not recall what LPN D said as she yelled at Resident #102 but described LPN D's response as aggressive. CNA J described LPN D as frustrated and frazzled.</p> <p>In an interview on 12/18/24, at 12:08pm, CNA H reported on the morning of 9/14/24, near the time of shift change, Resident #102 was seated near the nurse's station when she grabbed LPN D by the arm. CNA H reported LPN D responded by quickly getting face to face with Resident #102 and yelling Do not touch me, Do not touch me!. CNA H described LPN's appearance as very angry during her interaction with Resident #102. CNA H reported Resident #102 became increasingly agitated after the interaction.</p> <p>In an interview on 12/18/24 at 1:15pm, LPN E reported on the morning of 9/14/24, during change of shift, LPN D appeared very stressed and was trying hard not to snap but when Resident #102 hit her, LPN D turned around and said something to the resident in a tone that was more firm (sic) than it should have been. LPN E reported normally Resident #102 settled down easily but that morning she was difficult to redirect.</p> <p>In an interview on 12/19/24, at 9:10am, CNA F reported she witnessed LPN D yelling at Resident #102 on 9/14/24. CNA F reported the incident happened near the nurse's station, at the time of shift change. CNA F reported LPN D normally spoke in a somewhat loud tone of voice but described LPN D's tone of voice during this episode as an angry tone, louder than she normally speaks. CNA F reported after LPN D yelled, Resident #102 also began yelling, left the area, and pulled the lever on a fire alarm.</p> <p>In an interview on 12/19/24 at 12:53pm, LPN D reported on 9/14/24 she became overwhelmed while caring for Resident #102. LPN D described Resident #102 as playing crash um up [NAME] with my med cart and when LPN D tried to intervene, Resident #102 hauled off and punched me. LPN D did not report any attempts were made to determine why the resident was upset. LPN D reported when the resident made physical contact with her, she raised her voice at the resident, said Stop it, Stop it because she did not know what else to do. LPN D reported she immediately realized she was acting unprofessionally because the tone of voice she used toward the resident was abrasive, so she apologized to the coworkers who heard her. LPN D reported about 4 other residents were also nearby, along with Resident #102. LPN D did not report she apologized to any of the residents.</p> <p>In an interview on 12/19/24 at 1:59pm, Resident #102 could not recall the incident that took place on 9/14/24 but stated she felt the staff sometimes get angry with me.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #103</p> <p>Review of an Admission Record revealed Resident #103, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: difficulty walking, unspecified dementia without behavioral disturbance, and major depressive disorder (persistent feelings of sadness and low mood).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 11/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #103 was moderately cognitively impaired. Section H of the MDS revealed Resident #102 was frequently incontinent of bowel.</p> <p>Review of a Care Plan for Resident #103, with a reference date of 5/6/24, revealed a need/goal/interventions of: 1. (Resident #103) is incontinent of bladder and bowel R/T: impaired cognition and history of prostate cancer . he also occasionally has diarrhea. Goal: Will remain free of complications .Interventions: .provide incontinence care . 2. (Resident #103) has an actual behavior problem R/T (related to) TBI (traumatic brain injury). Goal: (Resident #103) will have fewer episodes of hallucinations .Interventions .approach in calm manner .</p> <p>Review of an Incident Investigation Report dated 9/14/24 revealed it was reported that Licensed Practical Nurse (LPN) D was witnessed yelling while in Resident #103's room assisting him after an episode of bowel incontinence.</p> <p>In an interview on 12/18/24, at 12:08pm, CNA H reported as she walked down the hall during the early morning hours of 9/14/24, she heard LPN D yelling from Resident #103's room. CNA H reported she heard LPN D yell he's shi**ing everywhere. CNA H reported after the encounter with LPN D, Resident #103 was quiet and withdrawn that morning.</p> <p>In an interview on 12/18/24, at 3:34pm, LPN D reported she was frustrated and overwhelmed on 9/14/24 and during rounding she discovered Resident #103 had been incontinent of bowel and she saw feces on the floor and on his bed. When further queried, LPN D admitted she used profanity while caring for Resident #103. LPN D stated I said shit because he was pooping everywhere. LPN D described her vocalizations as ranting to myself (sic) about the mess. I said there's sh** all over the floor.</p> <p>In an interview on 12/19/24 at 12:53pm, LPN D reported she received some additional training from the facility after the incident, but she felt she needed more comprehensive training to effectively provide dementia care. LPN D reported at some time in the last year the facility was coordinating an in-depth hands-on dementia care training, but the training never took place.</p> <p>In an interview on 12/19/24, at 8:33am, Resident #103 reported he was frequently incontinence of bowel, was frustrated about it, and sometimes felt self-conscious about his episodes of incontinence. Resident #103 did not recall the incident that occurred on 9/14/24 but when further queried, reported he would be bothered a bit if he heard staff swearing regarding his incontinence while they assisted him, and would not want that to happen. In the interview, Resident #103 was able to hear verbalizations presented at a normal tone.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/19/24, at 9:10am, CNA F reported she cared for Resident #103 regularly and he was frequently apologetic about his episodes of bowel incontinence. CNA F reported on 9/14/24, Resident #103 had been incontinent several times that night. CNA F described LPN D as frustrated and overwhelmed as she cared for Resident #103 on 9/14/24, so CNA F excused her from Resident #103's room, and took over his care.</p> <p>In an interview on 12/19/24, at 11:46am, former Nursing Home Administrator (NHA) C reported he investigated the incidents involving LPN D and her interactions with Resident #101, Resident #102, and Resident #103 on 9/14/24. NHA C reported based on his findings, LPN D received written final notice for misconduct and was required to take a computer-based classes. NHA C reported he was concerned with LPN D's responses to the resident's on 9/14/24 and opted to initiate disciplinary action so her performance could be monitored for 1 year, while the disciplinary action remained in her personnel file. NHA C reported he was unsure if any additional follow up had occurred because he no longer worked at the facility.</p> <p>Review of LPN D's employee file revealed no additional monitoring after the disciplinary action record dated 9/23/24.</p> <p>In an interview on 12/19/24 at 2:26pm, Director of Nursing (DON) B reported LPN D's responses to the situations that arose on 9/14/24, involving Resident #101, Resident #102, and Resident #103, were unprofessional. DON B reported the facility provided computer-based education related dementia behaviors for LPN D but felt it would be beneficial to provide more in-depth dementia care training. DON B reported the facility was working on offering more in-depth specialized dementia care training for staff, but it had not yet occurred.</p> <p>In an interview on 12/19/24 at 2:53pm, current Nursing Home Administrator (NHA) A reported he began his role at the facility about 6 weeks ago and was unaware of the facility reported incident that occurred on 9/14/24 involving LPN D.</p>		