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	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Galesburg	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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3052819.Based on interview and record review the facility failed to initiate cardiopulmonary resuscitation (CPR) and emergency medical services (EMS) for in 1 of 4 residents (R100) reviewed for acute change of condition, resulting in an Immediate Jeopardy, when on [DATE] R100 who was a full code, was found unresponsive and facility staff did not active EMS or initiate CPR. R100 subsequently was pronounce dead on [DATE] at 6:00am. Findings include:The facility failed to initiate CPR and EMS response for R100 who was a full code when found unresponsive on [DATE] at 5:50 AM. R100 was last seen on [DATE] at 4:45 AM when a breathing treatment was started and left during treatment. R100 was then not checked on again until 5:50 AM when she was found unresponsive and staff did not initiate CPR or EMS.The Immediate Jeopardy began on [DATE] when the facility failed to initiate CPR and call EMS on a resident with Full Code status. The Nursing Home Administrator was notified of the Immediate Jeopardy on [DATE] at 3:27 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on [DATE], prior to the start of the survey and therefore past noncompliance was granted.According to R100's admission Record, the resident was admitted to the facility on [DATE] from an acute care hospital.Review of R100's medical records diagnoses included acute and chronic respiratory failure with hypoxia (lack of oxygen to body tissue and organs) and hypercapnia (excessive amount of carbon dioxide) and COPD (chronic obstructive pulmonary disease). Review of R100's Advance Directives dated [DATE] revealed, Full CodeReview of R100's Order Summary dated [DATE] revealed, Full CodeReview of R100's Medication/Treatment Administration Record (MAR/TAR) dated [DATE]-[DATE], revealed, Advance Directive: Full CodeReview of R100's Progress Note dated [DATE] at 4:14 PM, revealed, .she (R100) wants to continue being full code status.Review of R100's Progress Note dated [DATE] at 8:52 AM, revealed, At approximately 0550 I went into residents' room to check on her and to let her know it was the end of my shift. When entered resident's room I said (R100) and there was no response so I walked closer and touched her shoulder and said her name again still no response. I checked her radial pulse it was absent. I came to the hallway and seen (name of oncoming nurse) the first shift nurse that was taking over for me, I yelled her name she didn't hear me so I came closer and said (R100) is gone (name of oncoming nurse) grabbed her stethoscope, I then checked the MAR for the resident's code statues and went into room with (name of oncoming nurse) as she checked resident apical pulse, it was absent. (name of night nurse) another nurse was also present and assessed resident, absent of apical pulse was also confirmed. Time of death was pronounced at 0600. It was noted there was no documentation in the progress note of found code status or the attempt to begin CPR or call EMS.During an interview on [DATE] at 11:22 AM, Family Member (FM) C stated, My mother wanted to be a Full Code. She had signed paperwork at the facility stating her wishes. She was able to make her needs known. On [DATE] at 6:36 AM, I received a call from (Registered Nurse (RN) G), saying my mother had passed away. When I received the call (R100) was dead, my sister, wife, and my three daughters went immediately. My brother was on facetime with us when we got to (R100's room). I asked (RN G) why (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she did not do CPR for (R100) and she said it was her fault because she panicked. At that time another nurse was with (RN G) and I asked if anyone else could do CPR and the two nurses did not answer me. The other nurse, I think it was the Charge Nurse, told us not to touch (R100) until the Medical Examiner (ME) had come to examine (R100). I asked why no one did CPR on (R100) because she was full code and again, no one answered me and the two nurses left the room. My sister that was there is an RN and kept asking why CPR was not done because (R100) was a full code. We were later told the cause of death was natural causes. CPR was not performed, EMS not called, the ME was called to pronounce (R100's) death. The death certificate says (R100) was dead at 6:00 AM. During an interview and record review on [DATE] at 12:50 PM, Licensed Practical Nurse (LPN) J stated while reviewing R100's medical record, I was (R100) admitting nurse on [DATE]. She had been a resident for some time and was constantly going to the hospital for respiratory issues. I asked her and her family what she wanted her code status to be. (R100) stated she wanted to be Full Code. Her documentation from previous readmission dated [DATE] was reviewed and she said she that is what she wanted, Full Code.During an interview and record review on [DATE] at 1:00 PM, Director of Nursing (DON) B stated, (R100's) code status was Full Code. (RN G) found (R100) unresponsive on [DATE] at 5:50 AM and did not initiate CPR. (RN G) did not check for (R100's) code status right away either. There were two other nurses that were called to the resident's room, (RN H and LPN M), neither of them initiated CPR or checked for (R100's) code status.During an interview on [DATE] at 5:45 PM RN G stated, At the end of my shift on [DATE] at 5:50 AM I went to tell (R100) I was leaving. She had been anxious most of the night shift because she had been readmitted and was using her BiPAP all the time. I last saw (R100) at 4:45 AM when I started her nebulizer treatment. (Certified Nursing Assistant (CNA) O) was in with (R100) after me. When I got into her room I was calling out her name over and over and she did not respond. Her eyes were closed. I touched her on the arm and there was no response. I called out her name again. I checked her radial pulse (pulse at wrist) and there was nothing. I went out to the hall and called for the incoming nurse (RN H) saying (R100) is gone! (RN H) came to (R100's) room and I thought to myself Shoot, I forgot to check (R100's) code status. I went to the computer to look up (R100's) code status and found she was a full code. I went back to (R100) and by then the other night nurse (Licensed Practical Nurse (LPN) M) was in the room. (LPN M) said (R100) was dead. So I thought with an experienced nurse telling me (R100) was dead, I didn't think of doing CPR. I did not call EMS. I called the on-call manager (Assistant Director of Nursing (ADON) F) who told me to call (R100's) family, the police, the Medical Examiner (ME), and Medical Director (MD). I did receive education and training on Death of a Resident prior to this incident. I am certified in CPR and was before this incident. I panicked when I found (R100) and did not follow what I was trained for.During an interview on [DATE] at 12:23 PM, FM D stated, (RN G) told the family she panicked and didn't start CPR or call EMS. I'm so upset. I lost my mother. There were other nurses in that facility that could have started CPR, that could have called EMS.Review of facility policy, Death of a Resident dated [DATE], revealed, When the resident's spontaneous respiratory and circulatory functions have ceased.CPR attempts have been exhausted, an evaluation is made. This begins the process of pronouncing the death of the resident.Death is reported to the facility administrator and/or the director of nursing. One of these two individuals, or designee, reports the death to the local authorities and/or agencies, as appropriate.When a resident is found to be without heartbeat and respirations, the nurse on duty identifies the code status. If the resident is Full Code status, CPR is started and emergency 911 services are activated .The nurse on duty contacts the attending physician/NP (nurse practitioner)/PA (Physician Assistant) and communicates the clinical information.Based on clinical information communicated from the nurse, the physician/NP/PA decides to come to the facility to pronounce the death of the resident or decides to make a pronouncement over the phone. If death is pronounced, the physician/NP/PA gives authorization to remove the body of the deceased resident.The Immediate Jeopardy that began on [DATE] was removed and the deficient practice corrected on [DATE] when the facility took the following actions to remove the (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediacy and correct the noncompliance:Medical Director was notified on [DATE].DON/designee educated Licensed Nurses on verifying code status when a resident is found without Vital Signs on [DATE].DON/designee provided education to all Licensed Nurses on [DATE] on Death of a Resident to include if resident is full code status, CPR is started and emergency 9-1-1 services are activated.Licensed Nurse who identified resident without VS was suspended immediately pending investigation on [DATE].100% audit of resident code status /supporting documentation was completed on [DATE]. Any concerns were addressed immediately. Code status was verified to be accurate and readily available on [DATE].DON/designee audited to ensure all Licensed Nurses were CPR certified with no expired licenses. 100% of Licensed Nurses were in compliance.DON/designee reviewed the crash cart, AED, and emergency management supplies on [DATE].NHA/DON reviewed advanced directive policy and death of a resident and deemed appropriate on [DATE].Ad-HOC QAPI was completed [DATE].The Licensed Nurse was reeducated one on one for responding to a resident without VS, how to verify code status, and notifying EMS on [DATE] prior to return to work. DON/Designee will complete Code Blue drills with varied shifts monthly for 90 days. DON will review audit findings in QAPI monthly for 90 days.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3052819.Based on interview and record review, the facility failed to monitor a nebulizer (medicated breathing treatment) treatment and ensure supplemental oxygen was continuously supplied to one resident (R100) of one resident reviewed for respiratory treatment and continuous oxygen use, resulting in decreased consciousness. Findings include:According to R100's admission Record the resident was admitted to the facility on [DATE].Review of R100's medical records diagnoses included acute and chronic respiratory failure with hypoxia (lack of oxygen to body tissue and organs) and hypercapnia (excessive amount of carbon dioxide) and COPD (chronic obstructive pulmonary disease). Review of R100's Order Summary, dated [DATE], included:- Ipratropium-Albuterol Inhalation Solution 0.5-25 (3) mg/ml.3ml inhale orally every 4 hours for COPD (administered by a nebulizer machine). - 02 Saturation monitoring four times a day for oxygen monitoring- BiPAP (Bilevel Positive Airway Pressure, a non-invasive type of ventilator that helps you breathe by pushing pressurized air into your airways through a mask and alternates between two pressures: a higher pressure when you inhale and a lower pressure when you exhale). Settings- 30%, 18/10 02 bleed in: 4L Mask size: Medium Mask Type: Full face as needed during naps and daytime, with exception to while eating- Settings (BiPAP) - 30%, 18/10 02 bleed in: 4L Mask size: Medium Mask Type: Full face at bedtime for COPD, HX of hypoxic Resp failure- Oxygen 4L via Nasal Canula while eating, resume BiPAP when finished eating with meals for oxygenation-Replace O2 bleed-in tubing as neededReview of R100's Medication/Treatment Administration Order dated [DATE]-[DATE], revealed, Ipratropium-Albuterol Inhalation Solution 0.5-25 (3) mg/ml.3ml inhale orally every 4 hours for COPD. Start date [DATE] at 4 PM Discontinue date [DATE] at 6:46 AM. It was noted on [DATE] the 0400 (4 AM) dose was administered.Review of R100's O2 Sats Summary revealed no oxygen saturation readings had been documented for the resident on this specific form.Further review of R100's Vital Signs document revealed no vital signs (VS: blood pressure, pulse, respirations, oxygen saturation) were documented on the forms for [DATE] or [DATE]. Review of R100 Care Plan, Special Instructions, revealed Describe breath sounds over all lung aspects (ie: wheezes, rales, rhonchi) vital signs with 02 sats and details of respirations, describe the effectiveness of any respiratory treatments given, (ie: nebulizers.other respiratory medications, oxygen, etc.) describe resident activity level and endurance, describe any changes in loc, anxiety or order mental status changes, objective signs of impaired respiratory status (ie cyanosis, sob, use of accessory muscles ,cough and sputum production.)During an interview [DATE] at 11:22 AM Family Member (FM) C stated, The facility told me (R100) called for a nebulizer treatment at 4:45 AM (on [DATE]). (Registered Nurse (RN) G) found (R100) unresponsive at 5:50 AM who called me at 6:36 AM and told my mother (R100) was dead. When me and my family came in, we saw (R100) had the BiPAP mask off to the side of her face. I'm wondering if the nurse gave (R100) her nebulizer treatment and did not put the oxygen and BiPAP back on her after the treatment was done. I thought the nurse had to watch while the nebulizer treatment was being given. Then that way the BiPAP mask would have been put back on her. Oxygen should have been running during the nebulizer treatment. The nebulizer treatment was started around 4:45 AM according to facility staff, then (RN G) came back in around 5:50 AM, about 1-1:05 hours later. Usually, a nebulizer treatment takes about 10 minutes to do. Something does not sound right. (R100) should have had a nurse with her during her nebulizer treatment. (R100) needed oxygen 24/7.During an interview on [DATE] at 5:45 PM, RN G stated, I started (R100's) nebulizer treatment around 4:45 AM on [DATE]. She had asked for one and had been using her BiPAP all night long whether she was awake or sleeping. When I started (R100's) nebulizer treatment I only stayed for a few minutes then I left because I had other things to do like starting morning medication pass. (CNA- Certified Nurse Aide O) put (R100's) BiPAP mask back on her after the nebulizer treatment was over. I did not verify (R100's) BiPAP or oxygen had been put back on her (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the nebulizer was done. The BiPAP machine was still running at 5:50 AM when I found (R100) unresponsive. I called (CNA O) down to (R100's) room when I found (R100) unresponsive. (CNA O) took off (R100's) mask because she thought she was going to have to do post-mortem care. I do not know whether the mask (CNA O) took off was for the nebulizer treatment or the BiPAP machine. I don't know if (R100) was wearing oxygen during the nebulizer treatment. I have had training on how to administer a nebulizer treatment prior to this incident. CNAs take off the nebulizer mask and put oxygen back on all the time.During an interview on [DATE] at 8:26 AM, FM C stated, My mother (R100) had severe respiratory issues. She had them for a long time and needed a BiPAP machine to blow off the excess CO2. Anytime my mother was at a facility her PCO2 would increase because of her anxiety being at the facility with a different BiPAP machine. She was afraid the facility would not have the right one. When staff called me on [DATE] to tell me my mother had died I was in shock. She was fine the night before. She had been readmitted to the facility from the hospital and the Administrator (Nursing Home Administrator (NHA) A) had come up to the hospital to make sure my mother had the right mask to wear with the BiPAP machine the facility was providing for her. When my family went to the facility that morning ([DATE]) to see my mother she had the BiPAP mask lying on her chest. The top strap that went around her head was off of her head and the mask's bottom strap was still around her neck. My sister was there too; she is a nurse. She saw that the BiPAP machine reported the machine had been on for 12 hours and 22 minutes. That did not seem right because the machine was started at on [DATE] at 3:30 PM, shut off at around 4 AM to do the nebulizer treatment that only takes 10-15 minutes, and then should have been started again. If the BiPAP was started again after the nebulizer treatment and she was found unresponsive at 5:50 AM, that is more than 12 hours and 22 minutes. The times on the machine and what the facility told me and my family do not add up. The nurse did not have my mother's BiPAP machine back on after the nebulizer treatment was done sometime around 5:00 AM. (Name of oxygen supply company) keeps records on file for machine use.Review of R100's BiPAP Compliance Report dated [DATE]-[DATE], revealed, Total usage: 12 hours 22 minutes. Device used: 03:54 PM to 06:28 PM (2 hours and 34 minutes). Device used: 06:57 PM to 04:42 AM (9 hours and 45 minutes). Device used: 06:21 AM to 06:24 AM. It was noted R100's BiPAP machine was turned off at 4:42 AM and not started again until 6:21 AM and then only for 3 minutes which was a total of 12 hours and 22 minutes. During an interview on [DATE] at 8:40 AM, Certified Nursing Assistant (CNA) O stated, I was assigned to (R100) on [DATE] nights into [DATE] morning. I did not stop the nebulizer treatment. I did not put the BiPAP mask on her. That is not my job, that is the nurse's job and responsibility.During an interview on [DATE] at 10:50 AM, RN G stated, I did leave her during the nebulizer treatment I started it around 4:13 AM. My morning med pass starts at 5:00 AM. We were short CNAs, one had to leave, so I was answering call lights. (CNA O) took off the nebulizer treatment and BiPAP mask back on. She said (R100) was messing with the nebulizer mask so she put the BiPAP mask back on. I did not go back in and check on (R100) until I found her unresponsive at around 5:50 AM and pronounced her dead with two other facility nurses at 6:00 AM.During an interview on [DATE] at 7:23 AM, Assistant Director of Nursing (ADON)/Staff Education F stated, CNAs are not to apply or discontinue a nebulizer treatment or place a BiPAP back on. That is a nurse's duty. When I talked to some CNAs about this yesterday, I learned that many CNAs are being asked by nurses to remove the nebulizer treatment masks and start oxygen via CPAP/BiPAP machines. That is not a CNAs job. Only a nurse can do this.Review of the facility's procedure, Nebulizer Therapy no date available of facility review, revealed, .An established component of respiratory care, nebulizer therapy aids bronchial hygiene by hydrating dried and retained secretions, promoting expectoration of secretions, humidifying inspired oxygen, and delivering medications to the lower respiratory tract.Avoid distractions and interruptions when preparing and administering medication to prevent medication errors.Obtain the patient's (resident's) vital signs, assess the respiratory status.Remain with the patient and continue the treatment until the nebulizer begins to sputter.After treatment, obtain the patient's vital signs, assess the respiratory status.Document the procedure.