Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235636	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Carson City	620 North Second Street Carson City, MI 48811

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint 2975929Based on interview and record review, the facility failed to ensure appropriate caregiver/support availability for an incapacitated resident who did not have a guardian/Power of Attorney and implement a safe discharge plan for one resident (Resident #1) out of 4 residents reviewed for discharge planning. Findings include:Resident #1 (R1)Review of the admission Record reflected R1 was admitted to the facility on [DATE] and again on 1/16/26 with diagnoses that included unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, a wedge compression fracture of the T11-T-12 vertebra, and hypertensive heart disease without heart failure. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] reflected R1 had a Brief Interview for Mental Status (BIMS) score of 13/15 indicating intact cognitive function. R1 did not have any mood disturbances or indicators of psychosis. A discharge, return not anticipated MDS assessment dated [DATE] reflected R1 scored a 12/15 on the BIMS, indicating moderate cognitive impairment. (This score suggests the individual may have some memory and thinking challenges but is not considered severely impaired.) Review of a Specific Durable Power of Attorney for Personal and Medical Care and Patient Advocate Designation, notarized on 12/3/2024 reflected that as of 12/3/2024, R1 had designated Family Member (FM) E to be their Power of Attorney (POA)/Patient Advocate; FM H was designated the successor POA in the event FM E was no longer willing or able to act as R1's POA. Attached to the Specific Durable Power of Attorney for Personal and Medical Care and Patient Advocate Designation was a letter, sent to FM E by the attorney representing the estate of R1, and indicated R1 no longer wished to have FM E act as their POA, thereby putting the successor POA (FM H) into effect as of 6/2/2025. A second attachment to the POA designation form reflected that two physicians had determined that R1 was unable to participate in treatment decisions on 5/7/2025 (seven months prior to R1 admitting to the facility).Review of an Activities Note dated 1/20/2026 reflected R1 reported that he lived at home with his wife. Review of a Nurses Note dated 1/20/2026 indicated R1's POA (FM H) reported concerns with R1's mental capacity. The nurse documented Pt (patient, R1) showing signs of confusion and cognitive decline.Review of a Statement of Capacity for R1 reflected This is to certify the above guest/resident (R1) has been examined by me and I have reviewed the medical record. I find this guest/resident: X to be incapable and unable to make his/her informed medical decisions. Note: Two practitioner examinations are needed to activate a Power of Attorney. The form was signed by the Medical Doctor (MD) B on 1/22/2026 and Medical Doctor (MD) C on 1/23/2026. The Statement of Capacity was received/reviewed by the facility Social Services Director (SSD) A as evidenced by SSD A's signature dated 1/26/2026.Review of an untitled memo, discovered in R1's Electronic Medical Record (EMR), dated 1/29/2026 reflected I (name of FM H) am resigning as Medical Power of Attorney for my brother (name of R1) as of 1/29/2026.Review of a Notice of Medicare Non-Coverage reflected Medicare Coverage of Your Current Skilled Nursing Facility Services Will End on 02/02/2026 . Sign below to show you received and understood this notice. I have been notified that coverage of my services will end on the date on this notice, and that I can appeal (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this decision by contacting my QIO (Quality Improvement Organization) and was signed by R1 on 1/29/2026, even though R1 was deemed NOT capable of making his own medical and/or treatment decisions as of 1/23/2026. The form was witnessed by Business Office Manager (BOM) I on 1/29/2026. Review of a Care Plan initiated on 1/18/2026, reflected R1 had a functional ability deficit and requires assistance with self-care/mobility r/t (related to) acute fracture of T11 (thoracic vertebra), worsening fracture of T12, anemia in CKD (chronic kidney disease), ulcerative colitis, metabolic acidosis, hyponatremia (low sodium in the blood), HTN (high blood pressure), falls, CKD stage 3, hyperlipidemia, COPD (Chronic Obstructive Pulmonary Disease), OSA (Obstructive Sleep Apnea), BPH (Benign Prostatic Hyperplasia), neuropathy, asthma, DM2 (Type 2 Diabetes). The goal of the care plan was that R1 would improve or maintain current level of function. Interventions included Home Safety Visit prior to discharge.During an interview on 4/16/2026 at 1:45 PM, Physical Therapy Assistant (PTA) D reported that a home safety visit was not completed with R1 prior to his discharge from the facility. Review of a Social Services Note dated 1/30/2026 reflected, Resident with planned discharge of 1/30/26. Resident (R1) requesting to discharge home with concerns noted from brother (FM H, former POA) regarding his safety being at home alone. Resident to have (name of home healthcare provider) PT (physical therapy), OT (occupational therapy), nursing, HHA (Home Health Aide) services upon discharge with a PCP (Primary Care Provider) app (appointment) on 2/5/26 at 10 AM with (name of provider) and office nurse. No new equipment needed to be ordered. This writer did provide resident (R1) and his brother (FM H, former POA) with a list of private duty nursing companies that may service the (name of community where R1 lived) area. Resident's brother stated that multiple nurses and a social worker from COA (Commission on Ageing) will meet with him next week. Resident's brother to transport via private vehicle around 10AM. During an interview on 4/14/2026 at 1:10 PM with the Nursing Home Administrator (NHA) and Social Services Director (SSD) A, SSD A reported that they were aware R1 had been deemed incompetent to make their own medical decisions and that FM H had provided written notice that they were unwilling to be the POA for R1. SSD A said that in situations where a resident lacked the mental capacity to make their own medical decisions and a POA was not identified, the facility would seek emergency guardianship via a partnership with a senior care network. SSD A reported the facility did not seek a public guardian for R1 due to believing FM H was still supporting R1, despite having provided written notice revoking their willingness to act as R1's POA/Patient Advocate. SSD A said that a sister facility reached out to them asking for information about R1 when he admitted there, but said they never specified that R1 did not have a guardian or POA because the sister facility never asked. The NHA and SSD A reported they could not confirm they knew R1 was safe to discharge to his home alone without confirmation appropriate support services and a patient representative were set up. During an interview on 4/14/2026 at 2:04 PM, FM F reported that three days after discharging from the facility they discovered FM H had dropped R1 off at home and left the state. FM F said R1 was divorced, lived alone, very unkempt, could not manage his ileostomy (a surgical opening that redirects the small intestine through the abdominal wall to bypass a damaged large intestine, allowing waste to exit into an external pouch) and said there was feces all over R1's bedding and bedroom. FM F reported R1 did not have any food in the house, very little water, and had not been taking his medications because they were discovered in a black plastic bag, not set up in a pill box. FM F reported they never saw any evidence Home Health services had been set up for R1 and that R1's condition continued to decline resulting in an admission to a different, sister facility from the one R1 had discharged from on 1/30/26. According to FM F, when the sister facility contacted R1's previous facility, they were not told R1 needed a public guardian or POA. During an interview on 4/14/2026 at 3:15 PM, a representative from the home health agency listed in R1's discharge summary reported that R1 was never seen or evaluated by anyone with their agency and was never enrolled for services.