

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: 235636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER The Laurels of Carson City		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Incident 3042858Based on interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of an allegation of abuse in accordance with section 1150B of the Act for one (R18) of four residents reviewed for abuse. Findings Include:R26Review of the Minimum Data Set (MDS) dated [DATE] revealed R26 was admitted to the facility 5/22/2026 with diagnosis that included Alzheimer's disease and Dementia. The MDS Brief Interview for Mental Status (BIMS) reflected a score of 0 out of 15 which indicated the Resident was severely cognitively impaired. The MDS reflected R26 was independently ambulatory.R18Review of the MDS date reflected R18 admitted to the facility 5/5/2024 with diagnoses that included Dementia. Review of the MDS BIMS reflected a score of 4 out of 15 which indicated R18 was severely cognitively impaired. The MDS reflected R18 was non-ambulatory and wheelchair dependent.A review was conducted of the initial report (MI-FRI-ID 00064918) submitted by the facility to the State Agency (SA) on 6/5/2026 at 9:00 AM. The initial report reflected on 6/4/2026 at 5:30 PM an allegation of abuse was identified when R26 was observed to inappropriately touch R18 prompting staff intervention. The documentation of this report reflected the incident was discovered in an Electronic Medical Record (EMR) entry on 6/5/2026. The entry reflected this was identified as an allegation of abuse and the facility Abuse protocol was implemented and an investigation began.On 6/23/2026 an interview was conducted with the Nursing Home Administrator (NHA) in the NHA office. The NHA reported on 6/5/2026 she had conducted the daily review of the EMR Clinical Alert Report. The NHA reported an entry documented by a Certified Nurse Aide (CNA) on 6/4/2026 revealed the inappropriate touching of R18 by R26 that had not been reported to the Abuse Coordinator according to facility policy as potential abuse. The NHA reported immediate actions were initiated to ensure resident safety and an investigation was initiated. The NHA acknowledged that timely reporting to the SA was not in accordance with facility policy or regulatory requirement. The NHA indicated that a plan was formulated and implemented to ensure future compliance with abuse prevention and reporting.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:- Initiation of an investigation on 6/5/2026 to identify details of the incident and to identify any potential deficient practice in relation to the incident.- Facility policy and procedure for Abuse were reviewed and deemed appropriate.- All facility staff education on abuse reporting and prevention began on 6/8/2026 and completed on 6/15/2026. Any staff who were not educated by this date are to receive this education prior to the start of their next shift.- One-on-one education was provided to the staff member directly involved in the delay of reporting the incident.- Audits were developed for employee education validation and to ensure there were no unreported concerns of abuse from residents.- A schedule of audits was formulated and implemented to ensure staff understanding of abuse prevention and reporting. Continued review by the QA Committee of the audit results was conducted.The facility was able to demonstrate monitoring of corrective action and maintained compliance.		

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent the development of a pressure ulcer for one resident (R7) of two residents reviewed for treatment of pressure ulcers. Findings include: Review of an admission Record revealed R7 admitted to the facility on [DATE] with pertinent diagnoses which included atrial fibrillation (a heart arrhythmia characterized by an irregular and often rapid heartbeat), depression, anxiety, and type 2 diabetes mellitus. Review of a current skin risk Care Plan for R7, initiated upon admission on [DATE], revealed R7 was at risk for impaired skin integrity/pressure injury related to urinary incontinence and type 2 diabetes mellitus, with an intervention initiated to cue to reposition self as needed and provide assistance to reposition as needed. Review of R7's Skin Issues note, dated 6/13/2026, revealed R7 had no new skin issues. Further review of the Electronic Medical Record (EMR) revealed R7 had no identified active skin issues on 6/13/2026. Review of R7's Nurses Notes, dated 6/13/2026 at 7:06 PM, revealed .patient refused to get up this (morning) for breakfast, stated she was in pain. pain meds given and ate breakfast in bed. patient was told she would need to get up for lunch and sit up for a short time, laying in bed is not good and could cause more pain, or pneumonia. No further documentation could be found in the EMR on 6/13/2026 or 6/14/2026 regarding R7's symptoms, activity, or ability to reposition self in bed. Review of R7's Nurses Notes, dated 6/15/2026 at 6:26 AM, revealed .Resident has new open area at the top of her coccyx. Area cleaned well and thin layer of zinc applied, covered with Optifoam. Wound team notified of new area. Review of R7's Skin Issues note, dated 6/15/2026 at 10:06 AM, revealed .New skin issue. Location: Coccyx. Issue type: Pressure ulcer/injury. Pressure ulcer staging: Stage 3 Pressure ulcer/injury- full thickness skin loss. Wound acquired in-house. It is unknown how long the wound has been present. Length (cm): 0.86 Width (cm): 0.6 Depth (cm): 0.3. Review of R7's impaired skin integrity Care Plan, initiated 6/15/2026, revealed generic interventions placed regarding conducting skin assessments and wound measurements, enhanced barrier precautions, observing for pain and signs of infection, and treating wound as ordered, but no resident specific or personalized interventions were formulated. In an interview on 6/23/2026 at 2:35 PM, Registered Nurse Unit Manager (RN UM) A reported she was not aware whether R7's new facility acquired pressure ulcer had been reviewed by the treatment team to discuss whether the wound was avoidable or to conduct a root cause analysis. RN UM A reported this was usually done at the weekly at risk team meetings, but she could not locate documentation in R7's EMR that this new wound was reviewed during the at risk meeting that took place on 6/17/2026. RN UM A reported she did not know how much assistance R7 currently needed to reposition in bed. In an interview on 6/24/2026 at 9:00 AM, the Director of Nursing (DON) reported facility acquired pressure ulcers are typically discussed during the weekly at risk meetings, but the pressure ulcer identified on R7's coccyx was missed and not discussed at the at risk meeting that took place on 6/17/2026. The DON replied that the treatment team had not yet discussed R7's new wound, and the Clinically Unavoidable Pressure Injury form had not been completed. R7's Care Plan was reviewed, and the lack of resident specific interventions was discussed. The DON reported she had started the Clinically Unavoidable Pressure Injury form and the care plan would be reviewed and updated. Review of facility policy/procedure Skin Management, revised 1/28/2026, revealed .It is the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. A ?Resident at Risk' meeting will be conducted at least monthly by the Interdisciplinary Team (IDT). During the meeting, the IDT will evaluate resident skin changes, review treatment modalities, interventions and will make recommendations as needed. Care plan and resident kardex will be updated accordingly.		

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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** Based on observation, interview, and record review, the facility failed to obtain a physician order for a continuous positive airway pressure (CPAP) machine and schedule cleaning for a CPAP machine for one resident (R88) of three residents reviewed for respiratory care. Findings include: Review of an admission Record revealed R88 admitted to the facility on [DATE] with pertinent diagnoses which included hypertension, sleep apnea, and chronic obstructive pulmonary disease. In an observation and interview on 6/22/2026 at 11:34 AM, R88 was lying in bed in her room. R88 had a CPAP machine that sat on her bedside stand and the mask sat on top of the machine uncovered. R88 reported that she used the CPAP machine the last three nights. R88 reported that the CPAP mask or humidifier container had not been cleaned or covered since her admission. Review of an Order Summary dated 6/22/26 at 12:43 PM, revealed no physician order for R88's CPAP machine or for the cleanliness of the CPAP machine. In an observation and interview on 6/23/2026 at 8:03 AM, R88 reported that she used the CPAP machine and wore the CPAP mask the previous night. R88 reported that facility staff did not clean the humidifier or cover the mask, but she still needed to wear it. The CPAP mask sat on top of the bedside stand, uncovered. In an interview and record review on 06/23/2026 at 11:49 AM, Unit Manager (UM) A reported that she had difficulty obtaining orders and CPAP machine settings from the corporate Respiratory Therapist. UM A reported that the physician orders for the CPAP machine and cleanliness of the CPAP were missed when R88 admitted to the facility on [DATE]. In an interview on 06/23/2026 at 12:46 PM, the Director of Nursing (DON) reported that R88's CPAP machine and cleanliness of the CPAP should have had physician orders upon admission on [DATE]. Review of facility policy/procedure Cleaning of Non-Invasive Respiratory Equipment reviewed 12/01/2022 revealed .Wash humidifier container with soap and water daily, rinse and let air dry. Refill container as needed for continued use. Wash tubing and mask weekly with soap and water, rinse and let air dry.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician reviewed monthly drug regimen review recommendations for 1 resident (R20) of 5 residents reviewed for unnecessary medications. Findings include: Review of an admission Record revealed R20 admitted to the facility on [DATE] with pertinent diagnoses which included heart failure, hypertensive heart disease, and dementia. Review of R20's drug regimen review Note to Attending Physician/Prescriber dated 5/6/2026 revealed .This resident has received cranberry for prevention of UTI (urinary tract infection). Please re-evaluate the continued use of cranberry supplement. Further review of a drug regiment review Note to Attending Physician/Prescriber dated 6/4/2026, revealed . This resident has advanced dementia with a BIMS (brief interview for mental status) of 3 (indicating severe cognitive impairment), and receives Aricept and Aspirin which may be of limited benefit in advanced dementia. There was no indication that the physician had reviewed these recommendations. In an interview on 6/24/2026 at 10:30 AM, the Director of Nursing (DON) reported R20's drug regimen review Note to Attending Physician/Prescriber dated 5/6/2026 and 6/4/2026 had not been reviewed by the physician. Review of facility policy/procedure Timeliness of Medication Regimen Review (MRR) Reports, last revised 9/7/23, revealed .The attending physician is expected to review the resident's individual MRR and document and sign that he/she has reviewed the pharmacist's identified recommendations withing 14 days of receipt.		