STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CON	ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		704050	B. WING			1/5/20	22
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CO	DE
LAURELS OF	HUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
F0000 SS=	Abbreviated surve M100122436, M1 M100123267, M1	dsonville was surveyed for	F0000				
F0602 SS= D	§483.12 The rest from abuse, neg resident property in this subpart. T limited to freedo involuntary sector chemical restrain resident's medic This REQUIREN evidenced by: This citation perta Based on interview failed to maintain accountability of ordered, labeled, a relief for one resid in three identified of the narcotic dru unavailable for us and the potential f and unavailability Resident and all fi	propriation/Exploitation ident has the right to be free lect, misappropriation of , and exploitation as defined his includes but is not m from corporal punishment, usion and any physical or nt not required to treat the al symptoms. MENT is not met as ins to intake M100125306. w and record review, the facility a system of security and Schedule II narcotic drugs and delivered for the use of pain lent (Resident #9 (R9), resulting incidents of misappropriation ges rendering the medication e by R9 if needed for pain relief for continued misappropriation of pain medication for this acility residents with pain huled medications.	F0602	Reside Reside to ensu- or if the schedu nursing the phy sheets manage were at Any iss time of The po narcotic and wa for med count, s etc. The nu ADON/ especia docume educate their ne The Do	nt #9 continues to reside in t nts receiving narcotics are ai nts receiving narcotics were ire that they still needed the ay needed it changed from P led etc. Orders were clarified management team in conju riscian group. The Narcotic c were reviewed by the nurse ement team to verify that the ccurate and signed out appro- ues or concerns were addre the evaluation. licies on Narcotic counts sign cs were reviewed by the QA is deemed appropriate. Upor is educated on the proper pro- dication pass which includes signing out narcotics, docum rses received re-education b DON/UM on medication pas ally narcotic counts and signi entation of narcotics. Those ed during initial re-education education upon their reporti ext date. in /Designee will audit weekly y x 3 that narcotic counts we	t risk. reviewed medication rn to d by the nction with ount counts opriately. ssed at the ning out committee n hire each oreceures narcotic entation y s, ng out and not will ng to work y x 4 and	2/8/2022
LABORATORY	DIRECTOR'S OR P	ROVIDER/SUPPLIER REPRESENT	ATIVE'S SIGN	ATURE	TITLE	(X6) DA	ГЕ
Electronical	ly Signed					02/03	/2022

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	STRUCTION		ATE SURVEY LETED
		704050	B. WING		1/5/20	_ 1/5/2022	
NAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
AURELS O	FHUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 4942	26	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	with diagnoses of: Conditions" that in Insufficiency, and the Minimum Data reflected R9 was of the MDS reflected On 12/15/21 the fa of possible diversi medication labeled the allegation to the investigation. The this investigation to days. On 12/21/21 abbreviated survey allegation. Review of the faci 12/15/21 at 6:00 A Hall night nurse, I "E", to the oncomi LPN "D", was in p investigation reflet two LPNs conduct on-coming shift co medications lister sheet (pink sheet) The facility invest count book, but no blister card was in facility was unable the blister card of labeled for the sold from the locked na	admitted to the facility 7/17/20 "Medically Complex Included Heart Failure, Renal Diabetes Mellitus. Review of a Set (MDS) dated 11/26/21 lognitively intact. Section J of that R9 is treated for pain. Accility identified an allegation on of Schedule II narcotic d for R9. The facility reported the state agency and initiated an facility reported the findings of to the state agency within five an unanounced, onsite, y was initiated to review the lity investigation reflected on LM shift changes from the West Licensed Practical Nurse (LPN) ing day shift West Hall nurse, progress. The facility cted during the shift change the ted a routine, off-going shift to but of the Scheduled intend in the West medication fics drawer. This count was paring the count of pills in each card to the corresponding count in the West cart narcotic book. igation reflected that a pink doses of hydrocodone (a but;) for R9 was in the narcotic to corresponding medication the narcotic drawer. The e to definitively conclude when fifteen doses of narcotics e use by R9 had been removed urcotic drawer. pharmacy Proof of Delivery		Any iss immedi QA by t audit th that the have a in the to monthly reporte The Fac	riately and all signatures a ues or concerns will be ad ately. The results will be re he DON. The DON or des e delivery sheets of narcoti pink sheet assigned and a otal count weekly times 4 v / times three. All findings v d to the QA committee cility allegation of Complia as the DON is responsible ince	dressed eported to ignee will tics to verify c drawer and are included weeks then will be nce will be	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	À. ÉUILDII	NG	STRUCTION		ATE SURVEY LETED 22
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE 3650 VAN BUREN HUDSONVILLE, MI 49426	E, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETIC DATE
F0607 SS= D	received for R9 a tablets on: Delivered on: 11/9 11/10/21 at 3:04 A Delivered on 11/2 11/24/21 at 1:15 A Delivered on 12/7 12/8/21 at 3:17 Al Review of the Me Records (MAR) fd December 2021 rd for the Schedule I The facility was n for any of these th narcotics meant fo Develop/Implem §483.12(b) The f implement writte that: §483.12(b)/ abuse, neglect, a and misappropri §483.12(b)(2) Es procedures to in allegations, and training as requi This REQUIREN evidenced by: This Citation perta Based on interview failed to follow th investigate an inju	3/21, received by LPN "D" on M. /21, received by LPN "X" on M. dication Administration or R9 for November and flected a current Doctor Orders I pain medication hydrocodone. ot able to provide an accounting ree deliveries of Schedule II	F0607	and ren Resider potentia able res any cor immedi The Ab commit were re Investig member PRN wi schedu facility s educate Investig Adminis	nt #7 continues to reside in the nains free from abuse. Its residing in the facility have t al to be affected. Staff and Inter sidents were queried regarding ocerns identified were addresse ately. use Policy was reviewed by the tee and deemed appropriate. S -educated on the Abuse Prohib jation and Reporting Policy. Sta rs who are on leave of absence II be re-educated on their next led work day. Upon hire and an staff will be educated and/or re- ed on the Abuse Prohibition, jation and Reporting Policy. The strator was re-educated on Abu ion, Investigation and Reporting	he view- abuse, d e QA taff ition, iff e or nually, e se	2/8/2022

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	À. BUILDII	NG	STRUCTION	(X3) DA COMPI 1/5/20	
		704050	B. WING			_ 1/5/20	22
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
LAURELS OF	HUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 4942	26	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
		lack of a through investigation, orting to the State Agency.			ally addressing the require mely and necessity of a th		
	Findings include:			bruise i	ation. The nurse who obsent nitially received education of unknown origin which in	on reporting	
	(R7) is a 76 year of the facility on 9/1 vascular dementia cerebral infarction	Sheet revealed Resident #7 old female originally admitted to 2/18 with pertinent diagnoses of , chronic kidney disease and n (stroke).		bruises Facility query s regardir monthly immedia	suspicious in nature. Administrator and/or desig taff and inter-viewable res og Abuse and audit weekly v x3. Concerns will be add ately and findings will be re Pl committee for further re	gnee will idents y x 4 and ressed eported to	
	12/9/21 indicated impaired and requ person assist for the assistance for dress	R7 is moderately cognitively ires supervision with one ransfers and extensive ssing.		Friday t and inci any inju abuse e	hendations. Daily Monday he IDT will review the 24-I dent and accident reports iny of unknown origin or all to was reported per the p	hour report to verify that legation of olicy. Any	
	revealed on 2/12/2 of unknown origin The facility report on her right breast Administrator (NI unaware of having got it. The facility through their inve provide informatic investigation inclu documented staff	ity Reported Incident (FRI) 11 the facility reported an injury 1 the facility diagonal 1 the facility distonal 1 the facility d		The Fac	vill be addressed immedia cility allegation of Complia as the Administrator is resp ince	nce will be	
	assessments that r residents were ass unknown origin. T occurred and the t from R7 "noted to use of walker and	eflected R7, and no other like essed for potential injuries of the facility concluded no abuse pruising on her right breast is prock herself when standing and at times uses her chest for then sit to stand occurs."					
	Total Body Skin A 12/11/21 for R7 re	ents titled "Skin & Wound- Assessment" dated 12/4/21 and evealed no findings. No skin nented between these dates or on					

						(1/0) B	
AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	G	ISTRUCTION		ATE SURVEY LETED
		704050	B. WING			1/5/20	22
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
LAURELS OF		(THE)			3650 VAN BUREN		
		(HUDSONVILLE, MI 4942	26	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	12/12/21.						
		nent titled "Skin Observation" 12/19/21 revealed R7 had no					
	for R7 revealed: "T Number of news skin assessment of	ng Progress Note dated 12/4/21 Fotal Body Skin Assessment" skin conditions: 0. Comments: complete, skin intact, will to bilateral ankles."					
	for R7 revealed: "C on upper right breat thigh" No thorou documented. Docu Nurse (LPN) "J" and	ng Progress Note dated 12/6/21 Greenish yellowish bruise noted ast and front of lower right ugh skin assessment umented by Licensed Practical nd no documentation indicating d the family and physician were					
	for R7 created 12/1 effective date of 12 from skin assessme bruise to right brea	Entry" Nursing Progress Note 12/21 at 4:56 p.m., with an 2/11/21 revealed: "added noted ent resident has old faded 1st. Resident states she has no red but that no one has harmed					
	12/12/21 at 5:47 p. fading dark/purple Resident denies pa how it happened bu	ng Progress Note dated .m. for R7 revealed: "large old bruise noted to right breast. iin. States she does not know ut that no one harmed her in sage for daughter who has her d provider"					
	reported she had be sure how it happen	12/21/21 at 1:15 p.m., R7 ruising on her leg and was not hed. She denied any other ed she felt safe and had no					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	À. ÉUILDIN	G	ISTRUCTION		DATE SURVEY PLETED 022
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, ST 3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L VIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
	Licensed Practical when she saw that she reported it to t LPN "G" reported (CNA) "H" told he confusion if the br said the NHA was When questioned bruise, LPN "G" r bruise and did not was older and report move toward grav reiterated the NHA In an interview on "H" reported could when and how she she reported the br which nurse she to already. CNA "H" (did not specify w toileted. When que when R7 was sho could not rememb In an interview on Director of Nursin noticed a resident it to be reported ti Home Administra the nurse should assessment, but if description should necessarily formal reported the reside her daughter and s could have obtain queried about the was not reported, i bruise on her thigh	12/29/21 at 10:47 a.m., Nurse (LPN) "G" reported R7 had a bruise on her breast, he doctor and the manager. the Certified Nursing Assistant er about it and there was uise was reported or not, then already aware of the bruise. about the description of the eported it looked like an older document the size because it orted that older bruises can ity and change in size. LPN "G" A did know about the bruise. 12/29/21 at 10:50 a.m. CNA d not remember the details of e saw the bruise on R7, but said ruise to the nurse, (not sure old), who knew about the bruise reported she noticed a bruise wered that week, CNA "H" er. 1/5/22 at 10:43 a.m., the g (DON) reported if a nurse had a bruise, she would expect ght away to her or the Nursing tor (NHA). The DON reported o a complete head to toe skin a bruise is noticed, a be documented but not measurements. The DON ent did leave the facility to visit uggested several ways R7 ed a bruise on her breast. When bruise on her thigh and why it the DON was unaware of the n. When queried about concerns on R7s breast and thigh, the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CON	STRUCTION	(X3) DA COMPI	TE SURVEY ETED
704050	B. WING			1/5/20	22
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP COI	DE
LAURELS OF HUDSONVILLE (THE)			3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BYTAGFULL REGULATORY OR LSC IDENTIFYINGINFORMATION)		CORF	IDER'S PLAN OF CORRECTION (E. RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
 DON reported that could be scary and potentially be an indicator for sexual abuse. The DON reported she did not do a full skin assessment on R7 and suggested the Unit Manager would have done the skin assessments. In an interview on 1/5/22 at 11:30 a.m., the NHA described the process of how she does her investigations for injuries of unknown origin and reported for R7 she interviewed the resident. The NHA was not able to provide statements from staff or residents and did not do a skin sweep of like residents who could potentially have an injury of unknown origin. When queried about the bruising documented on 12/6/21, the NHA reported she did not investigate it or report it to the state agency. The NHA reported for this investigations he utilized an auditing tool dated 12/8/21, which was before the incident was reported to the State Agency is how she did rounds with staff and residents to ask general questions about abuse but not able to tell the specific questions asked. The police were not notified, and the potential root cause was not identified. No education provided to staff to prevent injuries of unknown to be documented and thoroughly investigated. Review of a policy titled "Skin Management" last reviewed 7/2021 revealed: "Bruises: 1. An Incident and Accident report is to be completed. 2. The licensed nurse is responsible for documenting bruise upon occurrence and monitoring until healed. 3. Notify the attending physician and responsible party of the occurrence, document the notification in the medical record and initiate an order, as needed." 					

-	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 704050		à. Buildin	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 1/5/2022	
	OVIDER OR SUPPLIE		1		STREET ADDRESS, CITY, STATE, ZIP CO 3650 VAN BUREN HUDSONVILLE, MI 49426		DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
	policy of this facil neglect, and abuse misappropriation of resources all far report any incidem mistreatment, inju misappropriation of alleged abuse a	Reporting" revealed: "It is the ity to prohibit mistreatment, of guests/residents and /or of guest/resident property or cility personnel will promptly t or suspected incident of guest ries of unknown source or of property/resources. Reports nd/or misappropriation will be ted to the Administrator and gated"						
F0609 SS= D	response to allege exploitation, or m must: §483.12(c violations involvi exploitation or m injuries of unkno misappropriation reported immedi hours after the a events that caus abuse or result in later than 24 hou the allegation do not result in serio administrator of officials (includin Agency and adu state law provide care facilities) in through establish (4) Report the re the administrator representative a accordance with State Survey Ag of the incident, a verified appropri taken.	eged Violations §483.12(c) In gations of abuse, neglect, inistreatment, the facility)(1) Ensure that all alleged ng abuse, neglect, istreatment, including wn source and of resident property, are ately, but not later than 2 llegation is made, if the e the allegation involve n serious bodily injury, or not urs if the events that cause o not involve abuse and do bus bodily injury, to the the facility and to other ing to the State Survey It protective services where es for jurisdiction in long-term accordance with State law hed procedures. §483.12(c) isults of all investigations to r or his or her designated and to other officials in State law, including to the ency, within 5 working days ind if the alleged violation is ate corrective action must be MENT is not met as	F0609	and rer Reside potentia 60 days reportin addition The nu receive unknow suspicia The Ab commit 1/28/22 the Reg Abuse require violatio exploita of unkn residen but not is made allegati bodily i events	nt #7 continues to reside in the nains free from abuse. Ints residing in the facility have al to be affected. Incidents for swere reviewed to ensure that ing requirements were met. No hal concerns were noted. rse who observed the bruise in d education on reporting injuri vn origin which includes bruise ous in nature. Use Policy was reviewed by the tee and deemed appropriate. 2 the Administrator was reeduc gional Clinical Coordinator on the Policy, specifically addressing ment of timely reporting of alle ns involving abuse, neglect, ation or mistreatment, including own source and misappropria t property to be reported immed later than 2 hours after the all e, if the events that cause the on involve abuse or result in se njury, or not later than 24 hour that cause the allegation do not abuse and do not result in ser njury.	the the last itially es of s e QA On ated by he the ged g injuries tion of ediately, egation erious s if ot	2/8/2022	

AND PLAN OF	F DEFICIENCIES CORRECTION VIDER OR SUPPLIE		A. BUILDIN	G	STRUCTION STREET ADDRESS, CITY, STATE 3650 VAN BUREN HUDSONVILLE, MI 49426	СО́МРІ 1/5/20	22
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	Based on interview failed to acknowled unknown and reedu resulting in an inju investigated timely continue, and delay Agency. Findings include: Review of a Face S (R7) is a 76 year of the facility on 9/12 vascular dementia, cerebral infarction Review of the Min 12/9/21 indicated H impaired and requi person assist for tra assistance for dress Review of a Facilit revealed on 2/12/2 of unknown origin The facility reporte on her right breast Administrator (NH unaware of having got it. The facility through their invess provide informatio investigation includ documented staff if or family interview assessments that re	imum Data Set (MDS) dated 7 is moderately cognitively res supervision with one unsfers and extensive		incident residen allegatie Concer findings commit recomm Friday t and inc any inju abuse e issues The Fa	Administrator and/or designee r t reports, query staff and inter-vi ts weekly x4, monthly x3 to ensi- ons have been reported appropi- ns will be addressed immediate is will be reported to the QAPI tee for further review and hendations. Daily Monday through he IDT will review the 24- hour to ident and accident reports to ve- iry of unknown origin or allegation etc was reported per the policy will be addressed immediately cility allegation of Compliance w as the Administrator is responsit- unce	ewable ure riately. ly and gh report rify that on of Any ill be	

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIF A. BUILDING	PLE CON	ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		704050	B. WING _			_ 1/5/20)22
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CC	DE
LAURELS OF	HUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 4942	26	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	unknown origin. T occurred and the bi from R7 "noted to use of walker and a stabilize herself wl Review of docume Total Body Skin A 12/11/21 for R7 re assessment docum 12/12/21. Review of a docum dated 11/24/21 to 1 skin concerns. Review of a Nursin for R7 revealed: "T Number of new s skin assessment of continue skin prep Review of a Nursin for R7 revealed: "T on upper right brea thigh" No thoro documented. Docu Nurse (LPN) "J" an it was reported and notified. Review of a "Late for R7 created 12/1 effective date of 12 from skin assessment bruise to right brea	he facility concluded no abuse ruising on her right breast is rock herself when standing and at times uses her chest for nen sit to stand occurs." Inst stitled "Skin & Wound- issessment" dated 12/4/21 and vealed no findings. No skin ented between these dates or on nent titled "Skin Observation" 12/19/21 revealed R7 had no ng Progress Note dated 12/4/21 Fotal Body Skin Assessment" skin conditions: 0. Comments: complete, skin intact, will to bilateral ankles." ng Progress Note dated 12/6/21 Greenish yellowish bruise noted list and front of lower right ugh skin assessment mented by Licensed Practical nd no documentation indicating I the family and physician were Entry" Nursing Progress Note 12/21 at 4:56 p.m., with an 2/11/21 revealed: "added noted ent resident has old faded ust. Resident states she has no red but that no one has harmed					
	12/12/21 at 5:47 p.	ng Progress Note dated m. for R7 revealed: "large old bruise noted to right breast.					

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STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTII A. BUILDING	PLE CON G			ATE SURVEY LETED
		704050	B. WING _			1/5/20)22
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STA		
						E, ZIP CO	UE
LAURELS OF		(THE)			3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE (FERENCED TO THE APPROPR DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	how it happened by	in. States she does not know ut that no one harmed her in sage for daughter who has her d provider"					
	reported she had be sure how it happen	12/21/21 at 1:15 p.m., R7 ruising on her leg and was not red. She denied any other ed she felt safe and had no					
	Licensed Practical when she saw that she reported it to the LPN "G" reported (CNA) "H" told he confusion if the bri said the NHA was When questioned a bruise, LPN "G" re bruise and did not was older and repor move toward gravit	12/29/21 at 10:47 a.m., Nurse (LPN) "G" reported R7 had a bruise on her breast, he doctor and the manager. the Certified Nursing Assistant er about it and there was uise was reported or not, then already aware of the bruise. about the description of the eported it looked like an older document the size because it orted that older bruises can ity and change in size. LPN "G" A did know about the bruise.					
	"H" reported could when and how she she reported the br which nurse she to already. CNA "H" (did not specify wh toileted. When que	12/29/21 at 10:50 a.m. CNA d not remember the details of saw the bruise on R7, but said uise to the nurse, (not sure old), who knew about the bruise reported she noticed a bruise here) when R7 was being pried if she noticed a bruise vered that week, CNA "H" er.					
	Director of Nursin noticed a resident l it to be reported rig	1/5/22 at 10:43 a.m., the g (DON) reported if a nurse had a bruise, she would expect ght away to her or the Nursing for (NHA). The DON reported					

STATEMENT OF DEF AND PLAN OF CORF			(X3) DATE SURVEY COMPLETED 1/5/2022				
NAME OF PROVIDER					STREET ADDRESS, CITY, STATE, ZIP CODE 3650 VAN BUREN HUDSONVILLE, MI 49426		DDE
PRÉFIX (EA	ACH DEFICIEN ULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
desc necc repo her o coul que was brui of b DOI be a repo R7 a don In a desc inve repo staff NHL staff like inju the l repo the s do a and inve repo staff NHL staff like staff not nece staff not staf not st	rription should essarily formal rted the reside daugher and s d have obtaine ied about the l not reported, t se on her thigh ruising noted of N reported that n indicator for orted she did no and suggested e the skin asses n interview on tribed the proc stigations for i rted for R7 she f, the roommat A was not able f or residents a residents who ry of unknown oruising docum rted she did no state agency. T full head to to documented it stigation she u v/21, which was rifed, and the put tified. No educ ent injuries of thoroughly inv	1/5/22 at 11:30 a.m., the NHA ess of how she does her njuries of unknown origin and e interviewed the resident, the e, and other residents. The to provide statements from nd did not do a skin sweep of could potentially have an origin. When queried about nented on 12/6/21, the NHA ot investigate it or report it to the NHA reported the nurse did we skin assessment on 12/12/21. The NHA reported for this tilized an auditing tool dated s before the incident was te Agency is how she did nd residents to ask general use but not able to tell the asked. The police were not otential root cause was not cation provided to staff to unknown to be documented					

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050			(X3) DATE SURVEY COMPLETED 1/5/2022			
	VIDER OR SUPPLI				STREET ADDRESS, CITY, STATE 3650 VAN BUREN HUDSONVILLE, MI 49426	, ZIP CO)E	
(X4) ID PREFIX TAG	(EACH DEFICIEI FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (I RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA' DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
	Incident and Acci 2. The licensed nu documenting brui monitoring until H physician and ress document the noti and initiate an orc Review of a polic Investigation, and policy of this faci neglect, and abuse misappropriation resources all fa report any incider mistreatment, inju misappropriation of alleged abuse a	y titled "Abuse Prohibition, Reporting" revealed: "It is the lity to prohibit mistreatment, e of guests/residents and /or of guest/resident property or acility personnel will promptly at or suspected incident of guest uries of unknown source or of property/resources. Reports ind/or misappropriation will be rted to the Administrator and						
F0610 SS= D	§483.12(c) In re abuse, neglect, the facility must: evidence that al thoroughly invest Prevent further p exploitation, or r investigation is i Report the resul administrator or representative a accordance with State Survey Ag of the incident, a verified appropri taken.	ent/Correct Alleged Violation sponse to allegations of exploitation, or mistreatment, §483.12(c)(2) Have alleged violations are stigated. §483.12(c)(3) potential abuse, neglect, nistreatment while the n progress. §483.12(c)(4) ts of all investigations to the his or her designated and to other officials in to State law, including to the enery, within 5 working days and if the alleged violation is fate corrective action must be MENT is not met as	F0610	and rer Reside potenti- 60 day thoroug addition Weekly The Ab commit 1/27/22 the Re Abuse necess Facility review to ensu	nt #7 continues to reside in the f nains free from abuse. Ints residing in the facility have th al to be affected. Incidents for th s were reviewed to ensure that a gh investigation was conducted. hal concerns were noted. v skin checks completed use Policy was reviewed by the tee and deemed appropriate Or 2 the Administrator was re-educa gional Clinical Coordinator on th Policy, specifically addressing th ity of a thorough investigation. Administrator and/or designee v incident reports weekly x4, mon tre incidents have been thorough gated. Concerns will be addressi	he le last a No QA n ated by e ne will thly x3 hly	2/8/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	À. BUILDIN	PLE CONSTRUCTION G	COMP	ATE SURVEY LETED
NAME OF PROVIDER OR SUPPL			STREET ADDRESS, CITY	ί, STATE, ZIP CO	DE
LAURELS OF HUDSONVILLE	E (THE)		3650 VAN BUREN HUDSONVILLE, MI 49	426	
PRÉFIX (EACH DEFICIE	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS- ROPRIATE	(X5) COMPLETION DATE
Based on intervia failed to provide unknown origin Ensure other resi unknown origin, resident safety. Findings include Review of a Fact (R7) is a 76 year the facility on 9/ vascular dementi cerebral infarctic Review of the M 12/9/21 indicated impaired and req person assist for assistance for dra Review of a Fact revealed on 2/12 of unknown orig The facility repo on her right brea Administrator (N unaware of havii got it. The facilit through their inv provide informat investigation inc documented staf or family intervia assessments that residents were as unknown origin. occurred and the	e Sheet revealed Resident #7 old female originally admitted to 12/18 with pertinent diagnoses of a, chronic kidney disease and n (stroke). inimum Data Set (MDS) dated I R7 is moderately cognitively uires supervision with one transfers and extensive		immediately and findings will be the QAPI committee for further recommendations. The Facility allegation of Comp 2/8/22 as the Administrator is re compliance	review and liance will be	

		T					
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY LETED
		704050	B. WING _			1/5/20	22
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE
LAURELS OF	HUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 4942	6	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
		at times uses her chest for hen sit to stand occurs."					
	Total Body Skin A 12/11/21 for R7 re	ents titled "Skin & Wound- assessment" dated 12/4/21 and vealed no findings. No skin ented between these dates or on					
		nent titled "Skin Observation" 12/19/21 revealed R7 had no					
	for R7 revealed: "" Number of new s skin assessment	ng Progress Note dated 12/4/21 Fotal Body Skin Assessment" skin conditions: 0. Comments: complete, skin intact, will to bilateral ankles."					
	for R7 revealed: "C on upper right brea thigh" No thorou documented. Docu Nurse (LPN) "J" as	ng Progress Note dated 12/6/21 Greenish yellowish bruise noted ast and front of lower right ugh skin assessment umented by Licensed Practical nd no documentation indicating 1 the family and physician were					
	for R7 created 12/2 effective date of 12 from skin assessme bruise to right brea	Entry" Nursing Progress Note 12/21 at 4:56 p.m., with an 2/11/21 revealed: "added noted ent resident has old faded ast. Resident states she has no red but that no one has harmed					
	12/12/21 at 5:47 p. fading dark/purple Resident denies pa how it happened by	ng Progress Note dated .m. for R7 revealed: "large old bruise noted to right breast. iin. States she does not know ut that no one harmed her in sage for daughter who has her					

AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTH A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY PLETED
		704050	B. WING _			1/5/20)22
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CC	DE
LAURELS OF	HUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPR DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	loa and tiger texted	l provider"					
	reported she had be sure how it happen bruises and reporte concerns.	12/21/21 at 1:15 p.m., R7 ruising on her leg and was not ed. She denied any other ed she felt safe and had no					
	Licensed Practical when she saw that she reported it to th LPN "G" reported (CNA) "H" told he confusion if the bri said the NHA was When questioned a bruise, LPN "G" re bruise and did not was older and repor move toward gravit	12/29/21 at 10:47 a.m., Nurse (LPN) "G" reported R7 had a bruise on her breast, ne doctor and the manager. the Certified Nursing Assistant r about it and there was uise was reported or not, then already aware of the bruise. bout the description of the ported it looked like an older document the size because it rted that older bruises can ty and change in size. LPN "G" a did know about the bruise.					
	"H" reported could when and how she she reported the br which nurse she to already. CNA "H" (did not specify wh toileted. When que when R7 was show could not remember In an interview on Director of Nursing noticed a resident I	1/5/22 at 10:43 a.m., the g (DON) reported if a nurse nad a bruise, she would expect					
	it to be reported rig Home Administrat the nurse should do assessment, but if a	th away to her or the Nursing or (NHA). The DON reported a complete head to toe skin a bruise is noticed, a be documented but not					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CON	STRUCTION	_ COMF	PATE SURVEY
		704050	B. WING _			1/5/2	022
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE
LAURELS O	F HUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 494	26	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	reported the reside her daughter and s could have obtain queried about the was not reported, bruise on her thigl of bruising noted DON reported tha be an indicator for reported she did n R7 and suggested done the skin assee In an interview on described the proc investigations for reported for R7 sh staff, the roomma NHA was not able staff or residents a like residents who injury of unknown the bruising docur reported she did n the state agency. 7 do a full head to tt and documented i investigation shout at specific questions notified, and the p identified. No edu prevent injuries of and thoroughly in Review of a polic, reviewed 7/2021 r Incident and Acci	a 1/5/22 at 11:30 a.m., the NHA cess of how she does her injuries of unknown origin and le interviewed the resident, the te, and other residents. The e to provide statements from and did not do a skin sweep of o could potentially have an a origin. When queried about nented on 12/6/21, the NHA ot investigate it or report it to The NHA reported the nurse did be skin assessment on 12/12/21 t. The NHA reported for this utilized an auditing tool dated as before the incident was the Agency is how she did and residents to ask general puse but not able to tell the asked. The police were not ootential root cause was not cation provided to staff to f unknown to be documented					

	NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 704050 B. WING			(X3) DATE SURVEY COMPLETED 1/5/2022			
	VIDER OR SUPPLIE F HUDSONVILLE				STREET ADDRESS, CITY, STATE 3650 VAN BUREN HUDSONVILLE, MI 49426	, ZIP COI	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETIOI DATE
F0684 SS= G	monitoring until h physician and resp document the noti and initiate an ord Review of a policy Investigation, and policy of this facil neglect, and abuse misappropriation of resources all fa report any incidem mistreatment, inju misappropriation of of alleged abuse a immediately report thoroughly investi Quality of Care § Quality of Care § Quality of care is applies to all treat facility residents. comprehensive a the facility must of treatment and ca professional star comprehensive p and the residents. This REQUIREM evidenced by: This citation perta Based on observat review, the facility and address pain a (Resident #6), resu	y titled "Abuse Prohibition, Reporting" revealed: "It is the ity to prohibit mistreatment, of guest/residents and /or of guest/resident property or cility personnel will promptly tor suspected incident of guest ries of unknown source or of property/resources. Reports nd/or misappropriation will be ted to the Administrator and gated" 483.25 Quality of care a fundamental principle that atment and care provided to Based on the assessment of a resident, ensure that residents receive are in accordance with baards of practice, the person-centered care plan,	F0684	His pair treated rehab w c/o pair walker t footwea All resid The Pa by the O appropt discuss so was address address and prm docume plan wr	nt # 6 continues to reside in the n was addressed and his pain is Resident is currently working wi ith full weight bearing status an n. Resident #6 is ambulating with throughout the facility with appro- in. dents with pain are at risk. in management policy was revie QA committee and deemed riate. The IDT reviewed resident if any resident was having pain it being addressed. any concerr sed at that time. Ints are evaluated for pain upon ion quarterly, with significant cha a. Any complaints of pain are assented, physician contacted and a itten that is person centered. Ints receiving pain medication are	being th d no h a opriate wed s to and if hs were ange sessed, a care	2/8/2022

AND PLAN OF (F DEFICIENCIES CORRECTION /IDER OR SUPPLIE	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 704050 R	Á. BUILDIN	G	STRUCTION	СО́МРІ 1/5/20	22
LAURELS OF	HUDSONVILLE ((THE)			3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	admitted to the fac pertinent diagnoses disorders, and a fra Review of the Min 12/2/21 revealed R independent for tra Review of a Facilit submitted to the St revealed R6 had ar the form of a fractu of R6's hip was don "acute fractures" in was noted to have bilateral elbows alt transferring withou and when did the a Unknown although November 29th, 20 at that time. Guest had injuries on bila noted walking and days after Remo and removed shoes another guest that we Review of an "Inci dated 11/29/21 for unwitnessed fall at tears on his bilatera his room toward hi that were on the fld also had shoes on t removed the items removed the shoes	imum Data Set (MDS) dated 6 was cognitively intact and		commu directio The Nu Rehab licensee manage docume commu especia an incre educate hire or o Nurse r reports compla especia ensure dentifie involver Any iss immedi The Far 2/8/202 complia	rsing management team along Service Director re-educated th d nurses and therapy team on t ement process, also for entation, review and thoroughne nication of any change in condi ally including new complaints of pase in complaints of pain. Anyo ed at that time will be educated on the next day they work. nanagement will review 24 hou to evaluate if any resident has int of pain or an increase in pain ally if any injury /fall etc has occi that no reports of concerns have ed that would require further ment, weekly x 4 and monthly x ues or concerns will be address ately with a report to QA quarte cility Allegation of Compliance w 2 as the Don is responsible for	her with the e he pain ses of tion pain or one not upon r a new n urred to e been 3. sed rly. vill be	

		i					
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CON	STRUCTION		ATE SURVEY LETED
		704050	B. WING _			1/5/20)22
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DE
LAURELS OF	HUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 494	26	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	out and his arms w	ere at his side.					
	12/7/21 revealed R TO TRAUMA" an subcapital fracture Review of an x-ray revealed: "Known possible SX. PT (p November 29 and Impression: There fracture of the righ Review of a Nursin 11/29/21 at 3:35 p. heard a loud crash, on his back in fron walker tipped over performed on upper resident painful bu arms. Skin assesse outer bilateral elbo head, scalp assesse open areas or raise Practitioner). Reside	ology Results Report" dated 6 had "ACUTE PAIN DUE d revealed he had a right with no displacement. 7 dated 12/14/21 for R6 right hip FX (fracture) eval for ratient) states falling on fracturing his right hip. appears to be a probably acute t inferior pubic ramus" ng Progress Note dated m. revealed at "(1:55 p.m.) resident observed on the floor t of the bathroom door with . Full range of mother rr and lower extremities, t able to stand and raise his d noted to have skin tears on ws, resident stated he hit his ed, and forehead assessed, no d bumpstiger text to (Nurse lent stated he tripped over the legged in near the bathroom,					
	there was noted to ground that had be the fall and also a v plugged in. Reside Velcro tennis shoe shoes measured 12 measured 10 inche removed out of the Review of a Nursin 11/30/21 at 1:32 p. reviewed with IDT resident observed on he tripped over con	be a black cell phone on the en pulled out the wall during white humidifier fan that was nt also noted to have on black s that were floppy at the toes, 5 inches residents feet s Items unplugged and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CON 3	ISTRUCTION		ATE SURVEY PLETED	
		704050	B. WING			1/5/2022		
IAME OF PRO	OVIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE	
AURELS O	F HUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 49426			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE	
		om to charge and guardian he could get him the right size						
	dated 11/30/21 for (Pretreatment): Is address pain? = N impacting treatmen Treatment: Pt (pat night causing incr	cal Therapy Progress Note R6 revealed: "Pre-tx skilled therapy needed to ursing to address Barriers nt? = Yes. Barriers Impacting ient) fell onto R (right) side last eases in pain with ex's tivity. Clarified accuracy of fall "						
	dated 12/1/21 for therapy needed to address Pt able approx. 1 min before had to lay back do	cal Therapy Progress Note R6 revealed: "Pre tx: Is skilled address pian? = Nursing to to sit EOB (edge of bed) for ore R hip pain increased and pt wn Barriers impacting Barriers Impacting Treatment: ed R hip pain."						
	dated 12/2/21 for i therapy needed to address SLR 2: extremity) only du (right lower extren demo'd (demonstr motion) on R LE di in pain from fall th Pt able to stand LE to help decreaa (complained of) n	cal Therapy Progress Note R6 revealed: "Pre tx: Is skilled address pain? = Nursing to x10 on L LE (left lower te to increased pain on R LE mity) when attempted. Pt ated) decreased ROM (range of compared to L LE 2* increases nat occurred earlier this week. and shift wt (weight) over to L se pain in R LE, however pt c/o ausea after standing for approx. return to supine"						
	dated 12/3/21 for therapy needed to addresspt stated	cal Therapy Progress Note R6 revealed: "Pre tx: Is skilled address pian? = Nursing to d his RLE would hurt too much (passive range of motion) on						

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 704050	À. BUILDIN	G	STRUCTION	_ COMF	ATE SURVEY 'LETED)22
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, 3650 VAN BUREN HUDSONVILLE, MI 494		DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	CTION (EACH D BE CROSS-	(X5) COMPLETION DATE
	dated 12/6/21 for F therapy needed to address LAQ at increased pain whe Review of a Nurshi at 2:18 p.m. for Re resident having inc since fall. NP (Nur for X-ray obtained Review of a Nurshi at 7:39 p.m. for Re notified of x-ray re (non-weight bearin Review of a Physic dated 12/7/21 for F therapy needed to addressPt had fall a c improvements with still experiencing i some activity B Yes. Barriers Impa RLE pain with WF Review of a Physic dated 12/8/21 for F therapy needed to address Pt (edu on RLE not bearin leg, avoiding layin fx (fracture) is at h about x-ray results was reported with	ng Progress Note dated 12/7/21 5 revealed: (Nurse Practitioner) sults. Resident to be NWB ng.)" cal Therapy Progress Note R6 revealed: "Pre tx: Is skilled address pian? = Nursing to ncreases in R LE pain when g) for longer than approx. 3 puple weeks ago and has made n abilities and pain, however is ncreased pain with WB and arriers impacting treatment? = acting Treatment: increased					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 704050 B. WING				PATE SURVEY PLETED			
	VIDER OR SUPPLIE			STREET ADDRESS, CITY, S 3650 VAN BUREN HUDSONVILLE, MI 49420				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPE DEFICIENCY)	CROSS-	(X5) COMPLETION DATE	
	do not reflect the c assessment for R6 In an interview on reported he remen had extreme pain d wondering why it done and was conc care. He reported hospital, his fractu In an interview on Licensed Practical was working the d around shift chang When she entered the floor with his v phone was plugge- pathway and an ai and the plugs were tripping over them head. LPN "J" rep instructed to see if legs and he eventu stood with no prob R6 complained of pain was or remen LPN "J" reported J days. LPN "J" rep the Nurse Practitic "Tiger Text". LPN	ctronic Medical Records (EHR) communication and pain 's right lower extremity. 12/21/21 at 12:45 p.m., R6 abered falling on 11/29/21 and the first day of the fall and was took 4-5 days to get an x-ray cerned about the delay in his when he finally went to the re was already starting to heal. 12/21/21 at 1:45 p.m., Nurse (LPN) "J" reported she ay R6 fell, and it happened the when she heard a loud crash. his room, he was laying flat on walker tipped over. A cell d in the wall along the walking r humidifier was on the floor e pulled out of the wall from R6 L. She was unclear if he hit his orted the resident was 'he could move his arms and ally was able to move. R6 olems and sat in his wheelchair. pain but not sure where the abered if he was able to rate it. R6 is a good historian most orted the fall was charted and oner (NP) was notified via ("J" could not remember if the d verified the Electronic EMR) did not reflect it. The NP acknowledged the incident						
	the next day on 11 reported R6 usuall hip and left should was unaware he ha x-ray showed whe	/30/21 in the EMR. LPN "J" y had a baseline pain in his left ler prior to this incident and ad pain in his right hip until the re the fracture was. LPN "J" increase pain when walking						

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 704050		À. BUILDIN	G	STRUCTION	_ COMF	(X3) DATE SURVEY COMPLETED 1/5/2022	
	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 3650 VAN BUREN HUDSONVILLE, MI 49426			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	D BE CROSS-	(X5) COMPLETIO DATE	
	 Practitioner (NP) nurses reached ou she immediately of reported she was to until then (12/7/21) after his fall on 11 pain in his "tush". In an interview on Director of Nursir one of the nurses of R6 fall on 11/29/2 R6 was on the flow window. His room into a wall socket tripped over. The move his extremit did not recall the room of the nurse she extremit did not recall the room of the setter "M" made her away were ordered. The chronic pain on hi pain at the time of she is not sure if the together regarding his pain. In an interview on reported she heard after it happened a came in to the facility utilizer notify healthcare proceeding was working with became aware of the because of pain, si and an x-ray were 	12/22/21 at 8:15 a.m., Nurse 'L" reported as soon as the t to her about R6 having pain, rdered an x-ray. NP "L" maware of R6 having any pain). When she saw R6 the day /30/21, he only complained of 12/22/21 at 8:23, the Assistant (g (ADON) reported she was hat responded when she heard 1. When she entered the room, or in a sitting position facing the imate had a cell phone plugged near the floor that the resident ADON reported R6 was able to ies and get up off the floor. She resident complaining of pain when the Unit Manager (UM) are of his pain and then x-rays ADON reported R6 had is left side and denied R6 had the fall. The ADON reported ne staff were putting the pieces the residents' fall incident and 12/22/21 at 8:35 a.m. UM "M" about R6 falling the next day and alerted the NP when she dity that day. UM "M" reported is a "Tiger Text" system to oractitioners of any resident " reported she remembers was up walking with his any pain. She knew therapy the resident and when she he resident refusing therapy ne notified the NP right away ordered. R6 rated his pain at a s backside and buttocks.						

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED 1/5/2022		
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE 3650 VAN BUREN HUDSONVILLE, MI 49426	, ZIP COI	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	Rehabilitation Dir unaware of R6 ref therapy staff to no resident is having therapy staff com with the nursing si utilize a "Tiger Te the system worked Interdisciplinary T Tuesdays to discu therapy. On 1/7/2. discussed R6s' con with UM "M". WI' documentation for needed to address and what that mea it was communica the residents pain. Review of a polic; revised 7/2021 rev evaluate and ident determine the type develop a care pla Review of a polic; revised 7/2021 rev identify hazards a	y titled "Pain Management" last vealed: "The facility will ify guests/residents for pain, , location and severity and n for pain management." y titled "Fall Management" last vealed: "The facility will nd guest/resident risk factors erventions to minimize fall and					
F0689 SS= G	Accidents. The f §483.25(d)(1) Th remains as free possible; and §4 receives adequa assistance device	ision/Devices §483.25(d) acility must ensure that - ne resident environment of accident hazards as is 83.25(d)(2)Each resident te supervision and ses to prevent accidents. IENT is not met as	F0689	Resider full weig Resider the facil shoes All resid	nt # 6 continues to reside in the t is currently working with reha yht bearing status and no c/o pa t is ambulating with walker thro ity and is wearing appropriate s lents with potential for falls are a l management policy was revier	b with ain. bughout sized at risk.	2/8/2022

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		ATE SURVEY LETED
		704050	B. WING		1/5/20	22
NAME OF PRO	VIDER OR SUPPLIE	ER		STREET ADDRESS, CI	TY, STATE, ZIP CO	DE
LAURELS OF	HUDSONVILLE	(THE)		3650 VAN BUREN HUDSONVILLE, MI	49426	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF CORRECTIVE ACTION SHOL REFERENCED TO THE AF DEFICIENCY	JLD BE CROSS- PROPRIATE	(X5) COMPLETIO DATE
	evidenced by:			the QA committee and deem Residents' rooms were walke		
	This citation perta	ins to intake M100125065		ensure the room had no cord hazards present and any con	s or other trip	
	failed to ensure 1	w and record review, the facility (Resident #6) had an of clutter and accident hazards, with fracture.		addressed at that time. Resic was examined to ensure that fitting footwear any concerns at that time.	lents foot wear they had proper were addressed	
	Findings include:			Residents who were identified had their care plan reviewed the interventions were approp	to ensure that	
	Resident #6 (R6)			not at risk were discussed to had not missed identifying an falls.	ensure that they	
	admitted to the factor pertinent diagnosed disorders, and a fractor of the Min 12/2/21 revealed I independent for the Review of a Facili submitted to the S revealed R6 had a the form of a fractor of R6's hip was de "acute fractures" i was noted to have bilateral elbows al transferring without and when did the Unknown althoug November 29th, 2 at that time. Guess had injuries on bil noted walking and days after Remand removed shoe shoe shoe shoe shoe shoe shoe shoe	nimum Data Set (MDS) dated R6 was cognitively intact and		The facility assesses every re admission, quarterly and with change for fall risk. Any one i has a care plan developed th centered and based on the fa It is the facility policy to comp report with any fall with an int place to prevent reoccurrence completes a review with a RC any other necessary changes The nurse involved complete for any injury which includes assessment. Based on findin is involved to order any furthe The nurses continue to asses after any incident and docum with interventions. The physic responsible party are also no of the fall. The Nursing management tea Rehab Service Director re-ed licensed nurses and therapy process for documentation re thoroughness of communicat educated at that time will be o hazards and how to be on the	a significant dentified at risk at is person all risks identified. dete an incident rervention put in e. The IDT then CA and makes is to the care plan. is an assessment a pain gs the physician er testing etc is for 72 hours ent any changes cian and tified at the time am along with the lucated the team on the eview and ion. Anyone not educated upon vork. Nursing ucated on fall	

	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 704050 B. WING		(X3) DATE SURVEY COMPLETED 1/5/2022				
	ovider or supplie				STREET ADDRESS, CITY, S 3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT IN Review of an "Inci	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION) dent and Accident Report"	ID PREFIX TAG	CORI RE hazards	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROI DEFICIENCY)	E CROSS- PRIATE	(X5) COMPLETIO DATE
	unwitnessed fall at tears on his bilater his room toward hi that were on the fle also had shoes on di- removed the items removed the items removed the shoes found laying on hi out and his arms w Review of a "Radi 12/7/21 revealed R TO TRAUMA" an subcapital fracture Review of an x-ray revealed: "Known possible SX. PT (p November 29 and Impression: There fracture of the righ Review of a Nursii 11/29/21 at 3:35 p heard a loud crash on his back in from walker tipped over performed on uppe resident painful bu arms. Skin assesse outer bilateral elbo head, scalp assesse open areas or raise Practitioner). Resii cords that were plu there was noted to ground that had be the fall and also a ' plugged in. Reside	R6 revealed he had an 2:00 p.m. and sustained skin al elbows. R6 was walking in is bed and tripped over cords por near the bathroom door. He hat were too big. The facility that were plugged in and that were too big. R6 was is back with his legs stretched ere at his side. ology Results Report" dated 16 had "ACUTE PAIN DUE d revealed he had a right with no displacement. / dated 12/14/21 for R6 right hip FX (fracture) eval for ratient) states falling on fracturing his right hip. appears to be a probably acute t inferior pubic ramus" mg Progress Note dated m. revealed at "(1:55 p.m.) , resident observed on the floor t of the bathroom door with 2. Full range of mother er and lower extremities, t able to stand and raise his d noted to have skin tears on ws, resident stated he hit his sd, and forehead assessed, no d bumpstiger text to (Nurse fent stated he tripped over the tagged in near the bathroom, be a black cell phone on the en pulled out the wall during white humidifier fan that was nt also noted to have on black s that were floppy at the toes,		reports have be involver Any iss immedi The Far 2/8/202 complia	ility invokes its right to IDR	f concerns quire further ly x 3. Iressed larterly. Ince will be a for	

						I	(0) = (
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		I) PROVIDER/SUPPLIER/CLI ENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION	_ Č((3) DA ⁻ OMPLI	TE SURVEY ETED
	70	4050	B. WING _			1/	/5/202	2
NAME OF PROVIDER OR SU					STREET ADDRESS, CITY,	STATE 70		c
		-			· · ·	STATE, ZIF	- 000	'C
LAURELS OF HUDSONVI	LE (1H	E)			3650 VAN BUREN HUDSONVILLE, MI 494	126		
PRÉFIX (EACH DEF	CIENCY JLATOR	IENT OF DEFICIENCIES MUST BE PRECEDED BY Y OR LSC IDENTIFYING RMATION)	ID PREFIX TAG	COR	JIDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS		(X5) COMPLETION DATE
	nches	nches residents feet Items unplugged and h/walkway."						
11/30/21 at 1 reviewed wit resident obse he tripped ov of shoes too another area notified to se in shoes." Review of a dated 11/30/2 (Pretreatmen address pain' impacting tre Treatment: P night causing (exercises) at w/ (with) nut Review of a dated 12/1/2 therapy need addressP approx. 1 mi had to lay ba treatment? = confusion, in Review of a dated 12/2/2.	32 p.m. 1 1DT (in ved on the records. 2 arge for h n room to if she co hysical 7 1 for R6 b): Is skill = Nursin ttment? = (patient) increases d activity ing." hysical 7 for R6 red d to addr able to si before F k down. Yes. Barr reased R hysical 7 for R6 red d to addr able to si before K k down. Yes. Barr reased R hysical 7 for R6 red d to addr able to si before K hysical 7 for R6 red d to addr able to si before K hysical 7 for R6 red hysical 7 hysical	Progress note dated for R6 revealed: "Fall terdisciplinary team); he floor in his room. Stated Resident noted to have pair him. Cell phones moves to b charge and guardian buld get him the right size Cherapy Progress Note revealed: "Pre-tx ed therapy needed to hg to address Barriers = Yes. Barriers Impacting if ell onto R (right) side last s in pain with ex's y. Clarified accuracy of fall Cherapy Progress Note evealed: "Pre tx: Is skilled ress pian? = Nursing to it EOB (edge of bed) for R hip pain increased and pt Barriers impacting iers Impacting Treatment: hip pain." Cherapy Progress Note evealed: "Pre tx: Is skilled ress pian? = Nursing to the pain increased and pt Barriers impacting iers Impacting Treatment: hip pain."						

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	À. BUILDING	G	STRUCTION	(X3) DATE SURVEY COMPLETED _ 1/5/2022		
	VIDER OR SUPPLIE F HUDSONVILLE				STREET ADDRESS, CITY, STATE, 3650 VAN BUREN HUDSONVILLE, MI 49426			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR(:FERENCED TO THE APPROPRIAT DEFICIENCY)	oss- co	(X5) OMPLETION DATE	
	LE to help decrease (complained of) na	and shift wt (weight) over to L se pain in R LE, however pt c/o ausea after standing for approx. return to supine"						
	dated 12/3/21 for 1 therapy needed to addresspt stated	cal Therapy Progress Note R6 revealed: "Pre tx: Is skilled address pian? = Nursing to d his RLE would hurt too much (passive range of motion) on						
	dated 12/6/21 for 1 therapy needed to address LAQ a	cal Therapy Progress Note R6 revealed: "Pre tx: Is skilled address pian? = Nursing to nd marches 2 x 15 on L only 2* en attempted on R LE."						
	at 2:18 p.m. for Re resident having in	ng Progress Note dated 12/7/21 6 revealed: "Therapy stating creased pain in his right hip rse Practitioner) notified. Order I."						
	at 7:39 p.m. for R	ng Progress Note dated 12/7/21 6 revealed: (Nurse Practitioner) esults. Resident to be NWB ng.)"						
	dated 12/7/21 for 1 therapy needed to addressPt had i WB (weigh bearin sec. Pt had fall a c improvements wit still experiencing some activity F	cal Therapy Progress Note R6 revealed: "Pre tx: Is skilled address pian? = Nursing to ncreases in R LE pain when g) for longer than approx. 3 ouple weeks ago and has made h abilities and pain, however is increased pain with WB and sarriers impacting treatment? = acting Treatment: increased B and MMT."						
	Review of a Physi	cal Therapy Progress Note						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	À. ÉUILDIN	G	ISTRUCTION		DATE SURVEY PLETED
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, ST 3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE
	address Pt (edu on RLE not bearin leg, avoiding layin fx (fracture) is at h about x-ray results was reported with ed about new WB healing process." Review of the Elec do not reflect the c assessment for R6 In an interview on reported he remen had extreme pain t wondering why it done and was conc care. He reported y hospital, his fractu In an interview on Licensed Practical was working the d around shift chang When she entered the floor with his y phone was plugged pathway and an aii and the plugs were tripping over them head. LPN "J" rep instructed to see if legs and he eventu stood with no prob R6 complained of pain was or remen LPN "J" reported I days. LPN "J" rep	address pian? = Nursing to cated) about new NWB status g any weight at all through R g on R side when in bed since ip Spoke with nursing staff from yesterday, fx on RLE new NWB status on R LE. Pt status and importance in etronic Medical Records (EHR) communication and pain 's right lower extremity. 12/21/21 at 12:45 p.m., R6 ubered falling on 11/29/21 and he first day of the fall and was took 4-5 days to get an x-ray cerned about the delay in his when he finally went to the re was already starting to heal. 12/21/21 at 1:45 p.m., Nurse (LPN) "J" reported she ay R6 fell, and it happened e when she heard a loud crash. his room, he was laying flat on walker tipped over. A cell d in the wall along the walking r humidifier was on the floor e pulled out of the wall from R6 She was unclear if he hit his orted the resident was he could move his arms and ally was able to move. R6 olems and sat in his wheelchair. pain but not sure where the ubered if he was able to rate it. R6 is a good historian most orted the fall was charted and oner (NP) was notified via					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	À. BUILDIN	G	ISTRUCTION		ATE SURVEY
		704050	B. WING _			1/5/20	JZZ
IAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CC	DE
AURELS OI	FHUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 49426	6	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE
	NP called back an Medical Record (F EMR reflected the the next day on 11 reported R6 usuall hip and left should was unaware he ha x-ray showed whe was aware R6 had with Physical The: In an interview on Practitioner (NP) ' nurses reached out she immediately o reported she was u until then (12/7/21 after his fall on 11 pain in his "tush". In an interview on Director of Nursin one of the nurses t R6 fall on 11/29/2 R6 was on the floo window. His room into a wall socket tripped over. The 2 move his extremit did not recall the r until a week later ' "M" made her awa were ordered. The chronic pain on hi pain at the time of she is not sure if th together regarding his pain. In an interview on	 ("J" could not remember if the d verified the Electronic EMR) did not reflect it. The NP acknowledged the incident /30/21 in the EMR. LPN "J" y had a baseline pain in his left ler prior to this incident and ad pain in his right hip until the re the fracture was. LPN "J" increase pain when walking rapy. 12/22/21 at 8:15 a.m., Nurse 'L' reported as soon as the to her about R6 having pain, rdered an x-ray. NP "L" maware of R6 having any pain). When she saw R6 the day /30/21, he only complained of 12/22/21 at 8:23, the Assistant g (ADON) reported she was hat responded when she heard 1. When she entered the room, or in a sitting position facing the immate had a cell phone plugged near the floor that the resident ADON reported R6 was able to ies and get up off the floor. She esident complaining of pain when the Unit Manager (UM) we of his pain and then x-rays ADON reported R6 had s left side and denied R6 had the fall. The ADON reported near the floor that the resident and the resident's fall incident and 12/22/21 at 8:35 a.m. UM "M" about R6 falling the next day 					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. ÉUILDIN	G	ISTRUCTION		PATE SURVEY	
		704050	B. WING _			1/5/2	022	
NAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CC	DDE	
LAURELS O	FHUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 49426			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE (FERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETION DATE	
	came in to the faci the facility utilizes notify healthcare p concerns. UM "M talking to R6 who walker and denied was working with became aware of to because of pain, sl and an x-ray were 1-3/10 scale on hit In an interview on Rehabilitation Dir unaware of R6 ref therapy staff to nor resident is having therapy staff com with the nursing s' utilize a "Tiger Te the system worked Interdisciplinary T Tuesdays to discu therapy. On 1/7/2 discussed R6s' com with UM "M". WI documentation for needed to address and what that mea it was communica the residents pain. Review of a policy revised 7/2021 rev evaluate and ident determine the type develop a care pla	and alerted the NP when she ility that day. UM "M" reported is a "Tiger Text" system to oractitioners of any resident " reported she remembers was up walking with his any pain. She knew therapy the resident and when she he resident refusing therapy he notified the NP right away ordered. R6 rated his pain at a is backside and buttocks. A 12/22/21 at 9:00 a.m., the ector (RD) "N" reported she is using therapy and expects the tify the nursing staff if a pain. When queried how the nunicates resident concerns taff, RD "N" reported they will ext" but could not elaborate how 1. RD "N" reported they have an Team (IDT) meeting on ss residents who are getting 1 they had an IDT meeting and mplaints of pain in his groin nen queried about the therapy e "Pre tx: Is skilled therapy pain? = Nursing to address" int, RD "N" reported that meant ted to the nursing staff about y titled "Pain Management" last realed: "The facility will ify guests/residents for pain, e, location and severity and n for pain management." y titled "Fall Management" last realed: "The facility will nd guest/resident risk factors						

STATEMENT OF DEFICIEN AND PLAN OF CORRECTIC		À. BUILDIN	IPLE CONSTRUCTION	(X3) D/ COMPI 1/5/20		
NAME OF PROVIDER OR S			STREET ADDRESS, CITY, 3650 VAN BUREN HUDSONVILLE, MI 494		DDE	
PRÉFIX TAG and impler	Y STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY GULATORY OR LSC IDENTIFYING INFORMATION) ent interventions to minimize fall and	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
F0755Pharmacy Srvcs/Pro §483.45 F provide ro biologicals under an The facility to adminis only unde licensed r facility mut (including accurate a and admin biologicals resident.§ The facilit services of §483.45(b) aspects of services in Established and dispo sufficient of reconciliar that drug account of and period This citation M1001224Based on in failed to m	n pertains to intake M100125306 and	F0755	F755 Resident #5, #9 are receiving the as ordered and they are being si requirement. Resident #1 no longer lives at th Residents receiving narcotics are to ensure that they still needed th or if they needed it changed from scheduled etc. Orders were clari nursing management team in co the physician group. The Narcoti sheets were reviewed by the nur management team to verify that were accurate and signed out ag Any issues or concerns were add time of the evaluation. The policies on Narcotic counts a narcotics were reviewed by the C and was deemed appropriate. Up nurse is educated on the proper for medication pass which includ count, signing out narcotics, doc etc. The nurses received re-educatio ADON/DON/UM on medication p especially narcotic counts and si documentation of narcotics. Those educated during initial re-educati and that the narcotics arrived an locked drawer per the inventory to issues or concerns will be addrest immediately. The results will be re-	gned out per e facility. e at risk. ere reviewed he medication of Prn to fied by the njunction with c count se the counts propriately. dressed at the signing out 2A committee con hire each procedures es narcotic umentation n by mass gning out and se not on will orting to work ekly x 4 were done are present d put into the notice. Any ssed	2/8/2022	

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050		À. BUILDIN	IG	STRUCTION	COMP	(X3) DATE SURVEY COMPLETED 1/5/2022	
	VIDER OR SUPPLIE		STREET ADDRESS, CITY, ST 3650 VAN BUREN HUDSONVILLE, MI 49426					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT II three residents Res (R5), Resident #1 being diverted, mi	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION) sident #9 (R9) and Resident #5 (R1).,), resulting in the narcotics sappropriated, not correlating	ID PREFIX TAG	CORI RE QA by t The Fa	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPF DEFICIENCY) he DON cility allegation of Compliance as the DON is responsible for	CROSS- RIATE	(X5) COMPLETIO DATE	
	 (MAR), and for na residents and the p unrelieved pain. Findings include: Resident #9 (R9) On 12/15/21 the fa of possible diversi narcotic medication allegation the state investigation. The 	on Administration Record arcotics to not be available for potential for residents to have acility identified an allegation on of resident Schedule II n. The facility reported the e agency and initiated an facility reported the findings of o the state agency within five		complia	nce			
	12/15/21 at the 6:0 West Hall night nu (LPN) "E", to the nurse, LPN "D", w investigation refle two LPNs who con shift to the on-con Scheduled medica medication cart lo count was conduct pills in each medic corresponding cou West cart narcotic reflected that a pir of hydrocodone (a in the narcotic cou medication blister drawer. Subsequer missing narcotics. reflected the previ	lity investigation reflected on 10 AM shift change from the Irse, Licensed Practical Nurse oncoming day shift West Hall vas in progress. The facility cted during the shift change the nducted a routine, off-going ning shift count of the tions contained in the West cked narcotics drawer. This ted by comparing the count of cation blister card to the nt sheet (pink sheet) in the book. The facility investigation ak sheet accounted for 15 doses Scheduled II narcotic) for R9 nt book, but no corresponding card was in the narcotic nt searches failed to locate the The facility investigation ous shift to shift Scheduled had been conducted without						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	STRUCTION		ATE SURVEY PLETED		
		704050	B. WING			_ 1/5/2022			
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE		
AURELS OF	FHUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 49426				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE		
	medication cart at LPN "W". The fac conclude when the narcotics had beer narcotic drawer. On 12/29/21 at 12 conducted with LI conference room. oncoming nurse fe 12/15/21. LPN "E process for the Sci the oncoming nurse the blister cards at book" (reviewing reported on the medication with the concoming nurse the blister cards at book" (reviewing reported on the medication cart na shift-to-shift narco blistered medication cart na nurse, LPN "D", v sheets and was cal number of doses r checked. LPN "E" number for hydroo stated she told LP UPN "E" reported Wonday and that t was in the narcotiv reported she reme another nurse that hydrocodone. LPP determined the mi could not be found On 12/28/21 at 3:2 conducted with th The DON reported with a report of m	LPN "D" accepted the West the start of her night shift from cility was unable to definitively e blister card of fifteen doses of a removed from the locked :05 PM, an interview was 'N "E" in the facility LPN "E" reported she was the or the day shift on Wednesday, " reported the shift change heduled drug count was to have se check the doses remaining in a dthe off-going nurse "has the the pink count sheet). LPN "E" orning of 12/15/21, during the otic count she was viewing the on cards that were in the West was reviewing the pink count ling out the documented emaining narcotic being reported LPN "D" called out a codone for R9 and LPN "E" N "D", "we don't have that". a thorough check of the cart d the blister card was not found. she had worked the previous he missing narcotic blister card c drawer at that time. LPN "E" mbered commenting that day to R9 no longer uses the N "E" reported when it was ssing blister card of narcotics d the Supervisor was notified. 27 PM, an interview was e Director of Nursing (DON). d on the morning of 12/15/21 phone call from the facility issing narcotics. The DON arrived at the facility a							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	ISTRUCTION		ATE SURVEY PLETED		
		704050	B. WING			1/5/20	022		
IAME OF PRC	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, S	TATE, ZIP CC	DDE		
AURELS O	FHUDSONVILLE	(THE)			3650 VAN BUREN HUDSONVILLE, MI 49426	5			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROI DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE		
	enforcement was a law enforcement a was informed of th The DON reported investigate any fur the subsequent fac more unaccounted DON reported tha for R9 had been d 11/23/21 but that for medication blister not be accounted for discrepancy with 1 narcotic) was also Review of the pol- titled, "5.4 Inventor Substances" last re facility representa inventory records facility should reg and discontinued is substances to the 1 medication invent inventory to the co- controlled substan- destruction to the The policy provid Storage and Expir Biological", last re reviewed. The pol Substance Storage that all controlled manner that maint security". And "12 Pharmacy perform inspection for eacl assist Facility in c	vas repeated and that law notified. The DON reported that rrived the following day and he unaccounted for narcotics. d law enforcement did not trther. The DON reported that cility investigation revealed I Schedule II narcotics. The t refill orders of hydrocodone elivered on 11/9/21 and the pink count sheets and the cards for these deliveries could for. The DON reported a Percocet (a Schedule II identified. icy provided by the facility ory Control of Controlled evised 1/1/13 reflected, "5. A tive should regularly check the to reconcile inventory. The ularly reconcile: 5.1 Current inventory of controlled log used in facility's controlled ory system; 5.2 Current ontrolled medication declining and to the resident's Medication ecord (MAR) (and) 5.3 Unused ices held in storage awaiting declining inventory record". ed by the facility titled , "5.3 ation Dating of Medications, evised 12/1/22 (sic)" was icy reflected, "13. Controlled exised 12/1/22 (sic)" was icy reflected, "14 controlled exises are stored in a ains their integrity and 0. Facility should request that h nursing station in Facility to omplying with its obligations cable Law relating to proper							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 704050		A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 1/5/2022		
NAME OF PROVIDER OR SUPPLIER LAURELS OF HUDSONVILLE (THE)			STREET ADDRESS, CITY, S 3650 VAN BUREN HUDSONVILLE, MI 4942				
PRÉFIX (E	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT FIX CORRECTIVE ACTION SHOULD I		ROSS-	(X5) COMPLETION DATE
med On was "S" not disc faci pha sub requ Rev ship recc tabl Del 11/2 Del 11/2 Del 11/2 Del 11/2 Rev Rev Rec Decc for not hyd an a Res Rev Ship	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING						

	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED	
		À. BUILDING B. WING		
	704050	B. WING _		1/5/2022
NAME OF PROVIDER OR SUPPLI	ER		STREET ADDRESS, C	ITY, STATE, ZIP CODE
LAURELS OF HUDSONVILLE	(THE)		3650 VAN BUREN HUDSONVILLE, MI	49426
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION (EACH (X5)
PRÉFIX (EACH DEFICIEI TAG FULL REGULA	NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	PREFIX TAG	CORRECTIVE ACTION SHO REFERENCED TO THE AI DEFICIENCY	ULD BE CROSS- PPROPRIATE DATE
(Percocet) 5-325	MG" tablets.			
Record" for the m R5 was prescribed (oxycodone-Aceta mouth at bedtime 10/5/2021 2000 -] The MAR reflectd her pain at a 1/10 Percocet as prescribed was requested from (DON). As of 4:3 reported the form medical records c for it. As of the er 1/5/2022, the "Co Use" form for the Acetaminophen 5 not been found an what happened to remained when th Resident #1 (R1) Review of a Face the facility on 7/2 multiple fractures Review of the "Co Use" document da form from the pha mg (milligrams) t needed" with a to 7/31/21 at 5:40 a: at 12:30 p.m. The was given to R1 a	edication Administration onth of October 2021 reflected d "Percocet Tablet 5-325 MG aminophen) Give one tablet by for Chronic Pain" -Start Date- D/C Date-10/6/2021 at 1504". ed that on 10/5/2021, R5 rated and was given one tablet of the ibed. ew on 12/22/2021 at 2:00 p.m., abstances Proof of Use" form m the Director of Nursing 0 p.m. on 12/22/2021, the DON had not been located and the lerk was going to keep looking do of the survey exited on ntrolled Substances Proof of 15 tablets of "Oxycodone- -325 MG" prescribed to R5 had d there was no accounting for the 14 tablets that would have e prescription was discontinued. Sheet revealed R1 admitted to 9/21 with pertinent diagnosis of and discharged on 8/18/21. ontrolled Substances Proof of tated 7/30/21 for R1 in a typed urmacy revealed "Oxycodone 5 o be given every 6 hours as tal count of 15 pills noted. On m. 1 tablet was signed out and EMR does not reflect the dose t 5:40 a.m. on 7/31/21. y 2021 Medication			

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTI	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	A. BUILDING			COMPLETED	
704050		B. WING _	B. WING		1/5/2022		
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE
LAURELS OF HUDSONVILLE (THE)					3650 VAN BUREN HUDSONVILLE, MI 49426	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	the resident receive mg at 00:00 (midn not reflect the "Co Use" typed sheet d given at 5:40 a.m. Review of a "Cont typed document da HCL 50 mg, Give hours as needed fo 8/1/21 a dose was not reflect on the M Review of a "Cont typed document da mg, Give 1 tablet needed for pain" fo tablet was "Droppe second signature fin narcotic was waste Review of the "Co Use" documents fo with an order for the every 6 hours. In an interview on Director of Nursin, R1 may not have a of Use" document because the staff n "Controlled Substa the narcotics on the "Co Use" form as proof the residents and fo The DON acknow educating the staff	cord (MAR) for R1 revealed ed and ordered Oxycodone 5 ight) and a 12:30p.m. and does introlled Substances Proof of lated 7/30/21 that a dose was rolled Substance Proof of Use" ated 7/30/21 for "Tramadol 1 tablet by mouth every 6 or pain" for R1 revealed on signed out at "12p" and does MAR as given to R1. rolled Substance Proof of Use" ated 8/4/21, "Tramadol HCL 50 by mouth every 6 hours as or R1 revealed on 8/7/21, a ed wasted" by the nurse and no rom another nurse verifying the ed. ntrolled Substance Proof of or R1 revealed no documents he scheduled Tramadol 50 mg 12/28/21 at 12:00 p.m., the g (DON) reported the reason "Controlled Substance Proof for the scheduled Tramadol is nay be using the "as needed" ance Proof of Use" to sign out ad. The DON reported the mes document/sign out the Controlled Substance Proof of f they gave the medication to orget to chart it in the MAR. ledged it is a problem and is . The DON reported that ses get pulled away after dication and forget to chart it.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	704050 B. WING					1/5/2022		
NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE,	ZIP CO	DE
LAURELS OF HUDSONVILLE (THE)						3650 VAN BUREN HUDSONVILLE, MI 49426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
R1 had several missing sheets and not scanned into the computer. The DON reported the medical records person has not had time to scan the "Controlled Substance Proof of Use" sheets into the computer even though this resident has been discharged since August. More proof of use sheets provided later in this survey.								