

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/24/2022	
NAME OF PROVIDER OR SUPPLIER LAURELS OF HUDSONVILLE (THE)					STREET ADDRESS, CITY, STATE, ZIP CODE 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)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0000 SS=	<p>Initial Comments</p> <p>On May 24, 2022, An Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems. At the survey, The Laurels of Hudsonville was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.</p> <p>The facility has 108 certified beds. At the time of the survey the census was 76.</p> <p>An exit conference was held at the conclusion of the inspection. The results of the inspection were discussed with the Administrator and the Maintenance Director.</p> <p>The requirement at 42 CFR, subpart 483.73 was determined to be met at the time of this survey.</p>			E0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/09/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/24/2022
NAME OF PROVIDER OR SUPPLIER LAURELS OF HUDSONVILLE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000 SS=	<p>INITIAL COMMENTS</p> <p>On May 24, 2022, A Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems. At the survey, The Laurels of Hudsonville was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and the 2012 Edition of NFPA 99, Health Care Facilities Code.</p> <p>The facility is a single story building of type II (111) construction built in 1964. The building is fully sprinklered and has supervised smoke detection in the corridors, spaces open to the corridors and in the resident rooms.</p> <p>The facility has 108 certified beds. At the time of the survey the census was 76.</p> <p>An exit conference was held at the conclusion of the inspection. The results of the inspection were discussed with the Administrator and the Maintenance Director.</p> <p>The requirement at 42 CFR, subpart 483.90(a) is not met as evidenced by:</p>	K0000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/24/2022
NAME OF PROVIDER OR SUPPLIER LAURELS OF HUDSONVILLE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0211 SS= E	<p>Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure exit access corridors were clear of all obstructions in accordance with LSC 19.2.3. This deficient practice could potentially affect 16 occupants of the facility in the event of delayed egress because of obstructions during an emergency evacuation.</p> <p>Findings include:</p> <p>On 5/24/22 at 1:50pm, observation revealed a Trophy Case hanging on the corridor wall which exceeds a 4 inch noncontinuous projection allowances per LSC 19.2.3.4(2) and Americans with Disabilities Act (ADA) Accessibility Guidelines Section 307.</p> <p>These findings were confirmed during an interview with Maintenance #1 at the time of observation..</p>	K0211	<p>K211 Facility has removed trophy case from the wall to ensure clear access to exit points. Facility Administrator has re-educated Maintenance Director/designee on the requirement of maintaining a clear exit route without obstruction based on LSC 19.2.3.4 (2) and ADA Accessibility Guidelines Section 307. Maintenance Director has removed the trophy case and thus removed the obstacle. Maintenance Director/designee has achieved compliance and will monitor building routinely for maintenance of compliance. Administrator will be responsible for sustained compliance.</p>		6/21/2022
K0914 SS= D	<p>Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals</p>	K0914	<p>K914 Facility has tested receptacles not listed as hospital grade at patient bed locations and documented testing/ associated repairs or modifications on appropriate form and format.</p>		6/21/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/24/2022
NAME OF PROVIDER OR SUPPLIER LAURELS OF HUDSONVILLE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on records review and interview, the facility failed to ensure receptacles not listed as hospital-grade at patient bed locations are tested at intervals not exceeding 12 months. Records are maintained of required tests and associated repairs or modifications, contain date, room or area tested and results as required by 6.3.4 of NFPA 99. This deficient practice could affect an isolated number of occupants of the facility in the event of electrical failure due to lack of maintenance.</p> <p>Findings include:</p> <p>On 5/24/22 during the review of facility records between 9:00am and 12:30pm, there was no documentation available for the annual resident room electrical outlet tasks as required in NFPA 99, 6.3.3.2.</p> <p>These findings were confirmed during an</p>		<p>Facility Administrator has re-educated Maintenance director/designee on the requirement of the annual testing compliance as required by 6.3.4 NFPA 99. Facility Maintenance director will ensure annual tests are completed and in full compliance.</p> <p>Maintenance Director/Designee will monitor compliance through the review of the TELS system for annual inspections, concerns will be addressed immediately and reported to the QAPI committee for further review and recommendations.</p> <p>Administrator will be responsible for sustained compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 704050		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/24/2022	
NAME OF PROVIDER OR SUPPLIER LAURELS OF HUDSONVILLE (THE)					STREET ADDRESS, CITY, STATE, ZIP CODE 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)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	interview with Maintenance #1 at the time the records were reviewed.						