STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	704050	A. BUILDING _____ B. WING _____	8/3/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS The Laurels of Hudsonville was surveyed for an Abbreviated survey on 8/3/22. Intake Numbers: MI00128576, MI00128701, MI00128820, MI00129123, & MI00129775 Census= 79.	F0000		
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect and implement their abuse policy for one Resident (R5) from verbal sexual abuse, of 3 residents reviewed for abuse, resulting in R5 having feelings of frustrations, loss of self-worth and emotional distress, and the potential for further abuse of other residents. Findings include: Review of the facility abuse policy date last approved 4/28/22 revealed, "Each guest/resident shall be free from abuse, neglect, mistreatment,	F0600	F 600 Resident #5 continues to reside in the facility. Residents residing in the facility have the potential to be affected. Staff and Interview-able residents were queried regarding abuse, concerns were addressed immediately. The Abuse Policy was reviewed by the QA committee and deemed appropriate. Staff were reeducated on the Abuse Prohibition, Investigation and Reporting Policy. Staff members who are on leave of absence or PRN will be re-educated on their next scheduled work day. Upon hire and annually, facility staff will be educated and/or reeducated on the Abuse Prohibition, Investigation and Reporting Policy. The Administrator and Director of Nursing were reeducated by the Regional Clinical Coordinator on the Abuse Policy and the necessity of a thorough investigation on 8/16/2022 Facility Administrator and/or designee will query staff and inter-viewable residents regarding Abuse with random audits weekly x4, monthly x3. Concerns will be addressed immediately and findings will be reported to the QAPI committee for further review and recommendations. The Facility allegation of Compliance will be 8/31/2022 as the Administrator is responsible for compliance	8/31/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/26/2022

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.

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	exploitation, and misappropriation of property. Abuse shall include freedom form verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and physical or chemical restraint imposed for purposes of discipline or convenience that are not required to treat the guest's /resident's medical symptoms. Staff members, volunteers, family members, and other shall immediately report incidents of abuse and suspected abuse and should be assured that they will be protected against repercussions. Verbal Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause guest/resident to experience humiliation, intimidation, fear, shame, agitation or degradation regardless of there age, ability to comprehend or disability. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written or gestured communication, or sounds, to guest/residents within hearing distance, regardless of age, ability to comprehend or disability." Section E. "1. Allegations by anyone who becomes aware of verbal, physical, mental, sexual or emotional abuse and mistreatment, neglect, exploitation, involuntary seclusion or misappropriation of property must immediately report to his/her Administrator. 2. The Director of Nursing or designee with complete a assessment of guest(s)/resident(s) and document findings in the medical record." Section F, "1. If the accused is an employee of the facility, he/she will be suspended until the investigation has been completed. 5. Monitor the guest/resident closely, at least every 15 minutes, to assess behavior and to assure the guest/resident does not harm himself or herself. 6. The Director of Nursing or designee will complete an assessment of the guest/resident or guests/resident and document findings in the medical record. G. Reporting abuse and facility Response to the allegation. 1. The staff will report any allegation or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown sources to the			

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	Administrator and DON immediately. 2. The Administrator or designee will notify the guest/resident's representative. Also, any State or Federal agencies of allegation per state guidelines (2 hours if abuse allegation or serious injury; all other not later than 24 hours). Review of R5's face sheet dated 8/3/22 revealed she was a 60-year-old female that was never married and was admitted to the facility on 10/2/19. She had diagnoses that included: history of suicidal behavior, paranoid personality disorder, major depressive disorder, and history of adult physical and sexual abuse. R5 was her own responsible party. Review of R5's Brief Interview of Mental Status (BIMS) score dated 5/13/22 revealed she scored 15/15 (normal cognition). Review of a Facility Reported Incident (FRI) to the State on 7/9/22 at 9:13 AM revealed R5 was verbally abused by Physician "H" on 7/8/22 at 10:07 AM. The verbal abuse was substantiated by witness, Certified Nurse Aide (CNA) "L" and witness R6 (R5's roommate). CNA "L" stated she was in the room doing cares for R6 with the curtain pulled when she heard Physician "H" state to R5 "need to have more sex". R6 stated she heard Physician "H" make a statement about needing to have more sex. Interview completed with Physician "H" by the Director of Nursing (DON). Physician "H" stated he was doing a well-being visit to see how she was doing after her sister's recent passing. He said that R5 complained of not being able to sleep well and denies saying R5 "needs to have more sex." Review of R5's statement in the FRI dated 7/9/22 at 9:13 AM revealed, "R5 stated Physician "H" came in to check on her sister's passing and R5 stated she couldn't sleep, and Physician "H's"			

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comment was she "needed to have more sex". She said "sex?", he laughed and said "yeah". Then he said she is looking a little big and needed to lose some weight. R5 said she was surprised at his comment but was not emotionally distraught initially although brought it up to her nurse the following morning. Follow up on 7/11/22 with R5 states she feels no lasting effects from the comment although requested that she not have him as her physician moving forward.

Review of R5's FRI dated 7/9/22 at 9:13 AM conclusion revealed, "The facility was able to substantiate verbal abuse a thorough investigation process. Based on the events guest R5 described and roommate R6 and CENA "L" heard, the alleged comment was made to R5. Interview completed with Physician "H" who denied saying anything about sex. The facility has reached out to (name of company Physician "H" works for) throughout the investigation and Physician "H" has not returned to the facility since that allegation was reported."

Review of R5's FRI dated 7/9/22 at 9:13 AM revealed R5's Social Worker (SW) "M" was not interviewed.

During an interview with R5 on 8/2/22 at 10:10 AM, R5 stated, "Physician "H" made a very inappropriate comment. He told me I needed to have more sex and walked out when I told him I was having trouble sleeping." R5 said she was very offended by Physician "H's" comment. She said it made her feel uncomfortable and she requested not to have him as her physician.

During an interview with CNA "L" on the telephone on 8/3/22 at 9:50 AM CNA "L" confirmed she was in R5's room on the morning of 7/8/22 provided care for R5's roommate R6 when Physician "H" stopped by. CNA "L"

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	confirmed she heard R5 complain about not being able to sleep and heard Physician "H" respond, "you need to have more sex and laughed." CNA "L" said as Physician "H" was walking out the door he told R5 she was looking big and needed to lose weight. CNA "L" was very surprised and as soon as she completed care with R6 she went over to check on R5. CNA "L" said R5 was very upset and as she was going to report the event to the Director of Nursing (D0N) when Social Worker "M" walked in the room and CNA "L" reported to SW "M" what she heard and asked SW "M" if she was going to report the incident to the DON. CNA "L" said SW "M" said she would report it. CNA "L" said R5 was so upset by the event that she did not eat dinner that day. During an interview with the DON and Nursing Home Administrator (NHA) on 8/3/22 at 10:25 AM, they confirmed that they had not interviewed SW "M" during the investigation and were not aware SW "M" was aware of verbal abuse perpetrated by Physician "H" on 7/8/22. The DON and NHA said they did not do any discipline or reeducation of staff for not immediately reporting an allegation of abuse on 7/8/22 when they were aware Physician "H" had told R5 to "have more sex." During a telephone interview with SW "M" on 8/3/22 at 10:50 AM, SW "M" confirmed that CNA "L" and R5 had told her about Physician "H's" comment about needing to have more sex and R5 not sleeping. SW "M" denied CNA "L" asked her to report the incident to the DON. SW "M" confirmed she did not report the comment of having more sex to the DON because R5 was not upset. During a telephone interview with Licensed Practical Nurse (LPN) "K" on 8/3/22 at 11:47 AM, LPN "K" confirmed that she was working on			

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the morning of 7/9/22 and R5 complained that Physician "H" did not give her anything to help her sleep when she made the complaint to him yesterday. R5 said Physician "H" told her to have more sex. LPN "K" said R5 was not upset but she learned in school you report abuse, and she felt the comment was abusive, so she called the DON. LPN "K" said she does not think R5 has had any change in eating, activity or has showed any signs of emotional distress since the incident.

Review of R5's meal acceptance record for 7/8/22 revealed she ate 76% to 100% of a meal at 9:23 AM and at 20:03 (8:03 PM) at 13:22 (1:22 PM) it was documented that she refused to eat.

Review of R5's Social Service note dated, 7/8/22 at 11:07 AM revealed SW "M" did a well-being visit and R5 was reserved during the visit but reported she was "fine". "Continues to report missing her sister who recently passed away, however doesn't want to discuss it with SSD (social services director). R5 did report having difficulty sleeping. Stated she saw physician today and notified him. Emotional support was provided." There was no mention of Physician "H" comment about having more sex or that R5 was getting big and needed to lose weight.

Review of R5's Social Service note dated 7/11/22 at 8:27 AM, revealed "R5 notified SSD that she has a counseling appointment scheduled for today (7/11) at 1 pm via telehealth. Continues to report having trouble sleeping, Tiger text (facility communication system) was sent to provider by nursing staff on 7/10 for further follow-up. R5 reported she believes there was a miscommunication with physician she spoke with on 7/8. Discussed that she would like to see an alternative physician for primary care services at the facility. DON notified." There was no indication that Physician "H" had told R5 to have

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	more sex when she complained about not being able to sleep on 7/8/22. Review of Physician "H's progress notes for R5 on 7/8/22 at midnight revealed. Physician "H" saw R5 for a follow-up related to the death of her sister. "She seems to be coping well with the recent death of sister her in this nursing home. She is morbidly obese and does not adhere to diet. We stressed to her that she needs to be more active including 3 or 4 times a day flexion and extension exercise therapy and OT (occupational therapy). We will order dietary reconsult and reconsult PT (physical therapy) and OT (occupational therapy). No other significant new symptoms." There was no indication Physician "H" was aware R5 was having problems sleeping or treating her sleeping problems. There was no indication Physician "H" had told R5 to have more sex. Record review did not reveal any emotional or physical assessment being completed related to the allegation Physician "H" told R5 to have more sex when she complained of not being able to sleep. Record review did not reveal any emotional or physical assessment being completed related to the allegation Physician "H" told R5 to have more sex when she complained of not being able to sleep.			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F0609	F609 Resident #5 continues to reside in the facility. Residents residing in the facility have the potential to be affected. Incidents for the last 60 days were reviewed to ensure that reporting requirements were met. No	8/31/2022

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	hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report timely an allegation of verbal sexual abuse and protect other residents from potential verbal abuse for 1 (Resident R5) of 3 Residents reviewed for abuse, resulting in the potential for ongoing abuse when the alleged perpetrator was allowed to continue to work. Findings include: Review of R5's face sheet dated 8/3/22 revealed she was a 60-year-old female that was never married and was admitted to the facility on 10/2/19. She had diagnoses that included: history of suicidal behavior, paranoid personality disorder, major depressive disorder, and history of adult physical and sexual abuse. R5 was her own responsible party.		additional concerns were noted. The Abuse Policy was reviewed by the QA committee and deemed appropriate. On 8/16/2022 the Administrator was reeducated by the Regional Clinical Coordinator on the Abuse Policy, specifically addressing the requirement of timely reporting of alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property to be reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if events that cause the allegation do not involve abuse and do not result in serious bodily injury. Facility Administrator and/or designee review incident reports, query staff and inter-viewable residents with random audits weekly x4, monthly x3 to insure allegations have been reported appropriately. Concerns will be addressed immediately and findings will be reported to the QAPI committee for further review and recommendations. The Facility allegation of Compliance will be 8/31/2022 as the Administrator is responsible for compliance	

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Review of R5's Brief Interview of Mental Status (BIMS) score dated 5/13/22 revealed she scored 15/15 (normal cognition).

Review of a Facility Reported Incident (FRI) to the State on 7/9/22 at 9:13 AM revealed R5 was verbally abused by Physician "H" on 7/8/22 at 10:07 AM. The verbal abuse was substantiated by witness, Certified Nurse Aide (CNA) "L" and witness R6 (R5's roommate). CNA "L" stated she was in the room doing cares for R6 with the curtain pulled when she heard Physician "H" state to R5 "need to have more sex". R6 stated she heard Physician "H" make a statement about needing to have more sex. Interview completed with Physician "H" by the Director of Nursing (DON). Physician "H" stated he was doing a well-being visit to see how she was doing after her sister's recent passing. He said that R5 complained of not being able to sleep well and denies saying R5 "needs to have more sex." (Note the facility did not report the allegation of abuse to the State within 2 hours).

Review of R5's statement in the FRI dated 7/9/22 at 9:13 AM revealed, "R5 stated Physician "H" came in to check on her sister's passing and R5 stated she couldn't sleep, and Physician "H" commented that she "needed to have more sex". She said "sex?", he laughed and said "yeah". Then he said she is looking a little big and needed to lose some weight. R5 said she was surprised at his comment but was not emotionally distraught initially although brought it up to her nurse the following morning. Follow up on 7/11/22 with R5 states she feels no lasting effects from the comment although requested that she not have him as her physician moving forward.

Review of R5's FRI dated 7/9/22 at 9:13 AM conclusion revealed, "The facility was able to substantiate verbal abuse a thorough investigation

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	process. Based on the events guest R5 described and roommate R6 and CENA "L" heard, the alleged comment was made to R5. Interview completed with Physician "H" who denied saying anything about sex. The facility has reached out to (name of company Physician "H" works for) throughout the investigation and Physician "H" has not returned to the facility since that allegation was reported." (Note the Physician was not suspended on 7/8/22 when he allegedly verbally abused R5 due to administration not being notified until the following morning). During an interview with R5 on 8/2/22 at 10:10 AM, R5 stated, "Physician "H" made a very inappropriate comment. He told me I needed to have more sex and walked out when I told him I was having trouble sleeping." R5 said she was very offended by Physician "H's" comment. She said it made her feel uncomfortable and she requested not to have him as her physician. During an interview with CNA "L" on the telephone on 8/3/22 at 9:50 AM CNA "L" confirmed she was in R5's room on the morning of 7/8/22 providing care for R5's roommate R6 when Physician "H" stopped by. CNA "L" confirmed she heard R5 complain about not being able to sleep and heard Physician "H" respond, "you need to have more sex and laughed." CNA "L" said as Physician "H" was walking out the door he told R5 she was looking big and needed to lose weight. CNA "L" was very surprised and as soon as she completed care with R6 she went over to check on R5. CNA "L" said R5 was very upset and as she was going to report the event to the Director of Nursing (D0N) when Social Worker "M" walked in the room and CNA "L" reported to SW "M" what she heard and asked SW "M" if she was going to report the incident to the DON. CNA "L" said SW "M" said she would report it. CNA "L" said R5 was so upset by the event that she did not eat dinner that day.			

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During an interview with the DON and Nursing Home Administrator (NHA) on 8/3/22 at 10:25 AM, they confirmed that they had not interviewed SW "M" during the investigation and were not aware SW "M" was aware of verbal abuse perpetrated by Physician "H" on 7/8/22. The DON and NHA said they did not do any discipline or reeducate staff for not immediately reporting an allegation of verbal abuse on 7/8/22 when they were aware Physician "H" had told R5 to "have more sex."

During a telephone interview with SW "M" on 8/3/22 at 10:50 AM, SW "M" confirmed that CNA "L" and R5 had told her about Physician "H's" comment about needing to have more sex and R5 not sleeping. SW "M" denied CNA "L" asked her to report the incident to the DON. SW "M" confirmed she did not report the comment of having more sex to the DON because R5 was not upset.

During a telephone interview with Licensed Practical Nurse (LPN) "K" on 8/3/22 at 11:47 AM, LPN "K" confirmed that she was working on the morning of 7/9/22 and R5 complained that Physician "H" did not give her anything to help her sleep when she made the complaint to him yesterday. R5 said Physician "H" told her to have more sex. LPN "K" said R5 was not upset but she learned in school you report abuse, and she felt the comment was abusive, so she called the DON. LPN "K" said she does not think R5 has had any change in eating, activity or has showed any signs of emotional distress since the incident.

Review of R5's meal acceptance record for 7/8/22 revealed she ate 76% to 100% of a meal at 9:23 AM and at 20:03 (8:03 PM) at 13:22 (1:22 PM) it was documented that she refused to eat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	704050	A. BUILDING _____ B. WING _____	**8/3/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the facility abuse policy date last approved 4/28/22 revealed, "...Verbal Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause guest/resident to experience humiliation, intimidation, fear, shame, agitation or degradation regardless of there age, ability to comprehend or disability. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written or gestured communication, or sounds, to guest/residents within hearing distance, regardless of age, ability to comprehend or disability." Section E. "1. Allegations by anyone who becomes aware of verbal, physical, mental, sexual or emotional abuse and mistreatment, neglect, exploitation, involuntary seclusion or misappropriation of property must immediately report to his/her Administrator. 2. The Director of Nursing or designee with complete a assessment of guest(s)/resident(s) and document findings in the medical record." Section F, "1. If the accused is an employee of the facility, he/she will be suspended until the investigation has been completed. 5. Monitor the guest/resident closely, at least every 15 minutes, to assess behavior and to assure the guest/resident does not harm himself or herself. 6. The Director of Nursing or designee will complete an assessment of the guest/resident or guests/resident and document findings in the medical record. G. Reporting abuse and facility Response to the allegation. 1. The staff will report any allegation or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown sources to the Administrator and DON immediately. 2. The Administrator or designee will notify the guest/resident's representative. Also, any State or Federal agencies of allegation per state guidelines (2 hours if abuse allegation or serious injury; all other not later than 24 hours).			