STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235385	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Mt. Pleasant	400 South Crapo Street Mt. Pleasant, MI 48858

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the resident of the risks and benefits of a new psychotropic medication prior to initiation for 1 resident (R51) of 5 residents reviewed for unnecessary medications. Findings include: Review of an admission Record revealed R51 admitted to the facility on [DATE] with pertinent diagnoses which included anxiety disorder and major depressive disorder. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R51, with a reference date of 4/23/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R51 was cognitively intact. Review of R51's Social Services Note, dated 3/28/2025 at 4:21 PM, revealed the medical provider reviewed a recommendation from the mental health nurse practitioner for R51 to begin taking Pristiq (a psychotropic medication used to treat major depressive disorder). Review of R51's active Physician's Orders on 6/26/2025 at 11:00 AM revealed an order for Pristiq started 3/29/2025. Further review of the Electronic Medical Record (EMR) revealed no documentation that the risks versus benefits of Pristiq were reviewed with R51 prior to initiating treatment. In an interview on 6/26/2025 at 11:10 AM, Social Services Assistant E reported she could not find evidence that the facility had reviewed the risks versus benefits of Pristiq with R51. Social Services Assistant E reported the facility performed risk versus benefit education for antipsychotic medications but not for antidepressant medications. Review of facility policy/procedure Psychoactive Medication Management, revised 4/22/2025, revealed . Psychotropic Medication: Any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in categories of antipsychotics, antidepressants, antianxiety, sedatives or hypnotics, anticonvulsants, cognitive enhancers, herbal supplements, and melatonin . Before initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. An Antipsychotic Risk Benefit Medication Evaluation form will be completed . (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/26/2025 at 11:54 AM, R51 reported she did not know that she was taking Pristiq, and she did not remember receiving education regarding the risks versus benefits of Pristiq prior to starting this new medication. In an interview on 6/26/2026 at 12:16 PM, the Director of Nursing (DON) reported she had reviewed the EMR and could find no documentation that the risks versus benefits of Pristiq were reviewed with R51 prior to initiating this new medication.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care to dependent residents for three residents (R49, R30, and R81) of four residents reviewed for Activities of Daily Living. Findings: R49 Review of the Electronic Medical Record (EMR) revealed R49 was admitted to the facility 5/19/2023 with pertinent diagnoses that included generalized weakness and medically complex conditions. Review of the Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) dated 5/21/2025 reflected Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 out of 15 which indicated R49 was cognitively intact. The MDS Section GG on functional abilities reflected R49 could eat if staff set up the meal and was dependent on staff to roll the Resident in bed. The MDS reflected R49 was incontinent of bowel and bladder. On 6/24/25 at 12:38 AM the room of R49 was observed to be the last room on the hall and was around the corner making it the farthest room from the nurse's station. On entry to the room, R49 was observed laying on her left side on a flat bed. Next to the bed on an over-the-bed table was a lunch tray with the food covered in plastic and bowls with lids on them. R49 was asked why she had not touched her lunch. R49 reported she had been waiting for about thirty minutes for someone to prop her up so she can eat. R49 reported a staff member brought in her lunch tray and said, you need to get propped up and left the room. R49 reported she can eat on her own if staff will prop her up. R49 was asked if she had attempted to use her call light but replied that she didn't know where her call light was. The cord for the call light was observed behind and out of sight and out of the reach of the Resident. R49 also reported she did not know where her bed control was. On 6/24/25 at 12:51 PM, Certified Nurse Aide (CNA) C was observed collecting food trays from rooms post-meal. CNA C reported she was familiar with R49. CNA C was informed that R49 had now been waiting for over forty minutes for someone to return to her room to assist her to a position so she could eat. CNA C reported that R49 can use her call light, but no call light had been initiated by the resident requesting assistance. CNA C was informed that the Resident said she could not find her call light or her bed control. CNA C reported these were clipped to her dog and immediately went to the room. On entry CNA C observed the untouched meal and the Resident laying on her left side. CNA C retrieved the call light and bed control clipped to a stuffed dog and appeared to have fallen off the bed behind the Resident. R49 reported to CNA C that she was wet (with urine) and needed to be cleaned up. R49 had not been positioned to eat her meal while it was hot, was wet with urine and did not have access to a call light to summon staff when in need. The policy provided by the facility titled Call Lights last revised 3/12/2025 was reviewed. The policy reflected Policy: Call lights will be placed within the resident's reach and answered in a timely manner. And Procedure . 3. When a resident is in bed or confined to a chair ensure the call light is within easy reach of the resident. Resident #81 (R81) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R81's admission Record, dated 06/25/25, revealed R81 was re-admitted to the facility on [DATE] with multiple diagnoses that included Hemiplegia and Hemiparesis following cerebral infraction affecting right dominant side, aphasia, dysphagia, protein calorie malnutrition, depression and anxiety. R81's 06/03/25 admission MDS reflected resident was unable to participate due to her diagnosis. Review of the ADL's (Activities of Daily Living) revealed R81's Eating Self -Care as Needing Substantial/maximal assistance-Helper does MORE THAN HALF the effort. A review of R81's ADL care plan, last review dated 6/13/25, revealed R81 dependent on one staff member to assist to eat Date Initiated 5/20/2025. A review of R81's weights reflected, On 5/20/25 she weighed 168.4 pounds. On 6/23/25 she weighed 152.6 pounds and reflected a weight loss of 9.38%. On 6/25/25 at 12:10 PM, Certified Nurse Aide (CNA) K was observed closing the nearly empty 200 Hallway lunch cart as this surveyor entered R81's room. R81 was observed to be awake, lying in bed, without a meal tray on her bedside table. However, resident's roommate was observed sitting up eating her lunch. During an observation/interview on 6/25/25 at 12:10 PM, CNA K revealed R81's lunch was not in the 200-hallway meal cart. CNA K further revealed, her lunch might be in another cart I will go check. During an interview on 6/25/24 at 12:12 PM, Certified Nurse Aide (CNA) L revealed (Name of R81) typically does not eat lunch. She does not eat much at all. CNA L stated, she usually needs assistance and goes down to Dining room [ROOM NUMBER], however, (Name of R81) did not want to go. CNA L stated, we should assist (Name of R81) with her lunch in her room when she doesn't want to go (to the dining room), and she probably will just eat a couple bites if she eats. On 6/25/25 at 12:14 PM, R81 was observed sleeping in her bed. R81's Roommate was asked if they offered (Name of R81) any lunch? R81's Roommate stated, No, they just gave me my lunch and left. They didn't say anything to (Name of R81). On 6/25/25 at 12:19 PM, CNA K reported, they were making her a new tray for R81 and she would assist the resident with eating. On 6/25/25 at 12:22 PM, observation of R81's plate revealed that her lunch was pureed. R81 looked at her lunch, curled her nose up in disgust and shook her head no. One of the pureed items had a very thin consistency and was bright green in color. The other pureed food was dark brown and had a thin consistency. The food items were noted to be touching and mixing together. Overall, residents' lunch did not look appealing. CNA K asked R81 again if she would like a drink and to try just a little bite. R81 pointed at the plate and stated NO. During an interview on 6/25/25 at 12:37 PM, DON was informed about a concern with R81's recent weight loss and the lunch observation. DON stated she would have the Unit Manager follow up on it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/25 at 3:39 PM, Registered Nurse Unit Manager (RNUM) F provided a signed Educational Opportunity form. The form reflected that All residents should be offered and given a tray whether the resident refuses. The form also reflected under Goals/Expectations to Always give a food tray to resident. Resident #30 Review of an admission Record revealed R30 admitted to the facility on [DATE] with pertinent diagnoses which included heart failure and end stage renal disease. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R30, with a reference date of 6/9/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R30 was cognitively intact. Further review of same MDS assessment revealed R30 required assistance with bathing. Review of a current functional ability Care Plan for R30, initiated 5/7/2024, revealed resident preferred showers on non-dialysis days and required supervision of staff for baths and showers. In an interview on 6/24/2025 at 11:18 AM, R30 reported she did not always receive her showers. R30 reported staff would say she refused when she did not refuse or would say they would come back and then not come back. R30 reported she went to dialysis on Mondays, Wednesdays, and Fridays and wanted her showers to be on off days. R30 reported she had communicated to staff her desire to have showers on days that she did not have dialysis, but staff continued to offer her showers on dialysis days. Review of the facility shower schedule updated 10/30/2024 revealed R30's showers were scheduled to be completed on Thursdays and Sundays. This was handwritten on a typed schedule and therefore the start date of this schedule was unable to be determined. In an interview on 6/25/2025 at 3:30 PM, R30's shower sheets and task documentation were reviewed with Registered Nurse (RN) Unit Manager H. RN Unit Manager H reported staff were required to document showers on shower sheets and in the Electronic Medical Record (EMR) under tasks. RN Unit Manager H acknowledged there were dates she could not verify that showers were offered as scheduled on Thursdays and Sundays. RN Unit Manager H reported staff at times offered R30 showers on days she went to dialysis. RN Unit Manager H reported she was not sure when R30's shower days were changed to Thursdays and Sundays, as this was handwritten on the shower schedule. Review of R30's Census revealed she was out of the facility from 4/23/2025 to 4/26/2025, from 5/8/2025 to 5/15/2025, from 5/26/2025 to 5/29/2025, and from 6/13/2025 to 6/14/2025. Review of R30's shower documentation, including tasks and shower sheets, from 4/1/2025 through 6/25/2025 revealed the following . 4/13/2025 (Sunday)- received shower 4/18/2025 (Friday)- per task documentation refused shower 4/27/2025 (Sunday)- received shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation that a shower was offered or refused on scheduled shower days in April 2025 on 4/3/2025, 4/6/2025, 4/10/2025, 4/17/2025, or 4/20/2025. 5/7/2025 (Wednesday)- Shower sheet showed R30 refused shower. 5/21/2025 (Wednesday)- Shower sheet showed R30 refused shower and requested showers be offered on days she did not have dialysis. There was no documentation R30 was offered or refused a shower on scheduled shower days in May 2025 on 5/1/2025, 5/4/2025, 5/8/2025, 5/15/2025, 5/18/2025, 5/22/2025, or 5/25/2025. There was no documentation R30 received a shower on any of the 23 days she was in the facility in May 2025. 6/11/2025 (Wednesday)- Shower sheet showed R30 refused due to dialysis. 6/22/2025 (Sunday)- Shower sheet showed R30 received bed bath. There was no documentation R30 was offered or refused a shower on scheduled shower days in June 2025 on 6/1/2025, 6/5/2025, 6/8/2025, 6/12/2025, 6/15/2025, or 6/19/2025. According to provided documentation R30 received 1 shower/bed bath the 23 days she was at the facility through 6/25/2025. Review of the documentation of showers given, refused, and offered reflected an inconclusive record that gave support to the concern raised by R30.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to access, monitor and identify significant weight loss for 1 resident (R79) out of 18 residents reviewed for weight loss. Review of policy Weight Management last revised 9/22/23 revealed, Policy: Residents will be monitored for significant weight changes on a regular basis. Residents are expected to maintain acceptable parameters of nutritional status, such as unusual body weight and protein levels; . Further review of the Weight Management policy revealed, The Dietary Manager/RD and DON are responsible for coordination of an interdisciplinary approach to managing the processes for prediction, prevention, treatment, monitoring and calculation of unintended weight loss/gain. Review of Practice Guidelines reflects, .5. Residents determined to be at risk or have significant weight changes will be weighed on a weekly basis. Residents at risk are: . e. All new admits/re-admits for 4 weeks, f. Residents with insidious weight loss and; 5% in one month, 7.5% in 3 months, 10% in six months; g. Residents with the following clinical condition may also be at risk, this is determined by the IDT, Refusing to eat, Cancer, Diabetes, Depression, Dialysis, COPD, Malnutrition, Infection, Dehydration, Alzheimer's/dementia, . 7. Dietary Manager, Unit Manager and or/RD are to communicate weight changes to the IDT, attending physician and resident's responsible party. This is documented in the medical record. 8. Once an insidious weight loss is identified, the RD further assesses the guest/resident and makes recommendations as indicated to prevent/treat unintended weight loss. Findings include: Resident#79 (R79) Review of R79's admission Record, dated 6/25/25, revealed R79 was admitted to the facility on [DATE] with multiple diagnosis including: Partial Traumatic Amputation of Right Foot, Acute Osteomyelitis Right Ankle and Foot, Vascular Dementia, Depression, Anxiety Disorder, and Type 2 Diabetes Mellitus with Foot Ulcer. Review of the Minimum Data Set (MDS) dated [DATE] revealed R79 had a Brief Interview for Mental Status (BIMS) indicated he was severely cognitively impaired. A review of R79's Nutritional care plan, last reviewed on 5/23/25, revealed resident had a nutritional risk with interventions that included: obtain weight at a minimum of monthly. Report significant weight changes of 5% x 30 days, 7.5% X 90 days, or 10% X 180 days to physician and dietician. Further review of the Nutritional care plan reflected on 5/13/2025 the dietitian recommended ongoing weekly weights. A review of R79's weights reflected, On 5/07/25 he weighed 206.0 pounds. On 6/02/25 he weighed 188.4 pounds and reflected a weight loss of 8.54%. Further review of R79's weights reflected his weekly weight monitoring was discontinued on 6/02/25. During an interview on 06/25/25 at 11:25 AM, NHA was asked about weight loss concerns and monitoring of weights for R79. NHA revealed since February the facility had been without a dietary manager and they only had contract dietician working offsite for them one day a week. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 2:41 PM, DON revealed the facility had a new dietary manager starting on Monday and stated they would be going through and checking residents' weights. During interview DON provided further confirmation that R79 was trending downwards for significant weight loss. A review of R79's weight reflected, on 5/07/25 he weighed 206.0 pounds. On 06/25/2025, R79 weighed 184. 6 pounds reflecting a weight loss of 10.39 %. Review of R79's progress notes on 6/25/25 at 1549, revealed Med Pass was added TID instead of once daily and Health Shake was added TID to residents food plan due to weight loss. Will continue weekly weights with resident. Review of R79's medical record on 6/25/25 reflected the facility failed to complete a Diet History / Food Preferences Evaluation. Further review of R79's record revealed the evaluation was 45 days overdue.