STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235327	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Hudsonville (the)	3650 Van Buren Hudsonville, MI 49426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake MI00147718 Based on observation, interview, and record review, the facility failed to prevent the development and worsening of pressure injuries for one resident (Resident #1) out of 4 residents reviewed for pressure injury, resulting in worsening of pressure injury, serious infection, and delayed wound healing. Findings include: Resident #1 (R1) Review of an Admission Record reflected R1 admitted to the facility on [DATE] with diagnoses that included enterovirus, anemia, high blood pressure, chronic kidney disease, chronic congestive heart failure (CHF), atrial fibrillation with the presence of automatic (implantable) cardiac defibrillator, history of stroke, cognitive communication deficit, and muscle weakness. Review of a Minimum Data Set (MDS) admission assessment dated [DATE] reflected R1 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 13/15. R1 required partial to moderate assistance with rolling left and right, sitting to lying, lying to sitting on the side of the bed. R1 needed substantial/maximal assistance (helper does more than half of the effort) for sitting to standing and chair/bed-to-chair transfer. Section M - Skin Conditions reflected R1 was at risk for development of pressure ulcers and did not have any unhealed pressure ulcers or other skin conditions. Review of a Nursing Comprehensive Evaluation dated 9/12/24 (admission assessment) reflected R1 admitted to the facility with scattered bruising to the back of the right hand, a dark purple dot under an unspecified right toe, recent left arm cellulitis per hospital report. Swelling noted, no pain, no redness. No other skin alterations were noted in the admission assessment. Review of a Care Plan initiated on 9/12/24 reflected R1 was AT RISK for impaired skin integrity/pressure injury. The goal was to Minimize risk in an effort to reduce likelihood of pressure injury development. Interventions included cueing R1 to reposition self as needed and Follow facility policies/protocols for the prevention/treatment of impaired skin integrity. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/13/24 at 10:43 AM, R1 reported he had some difficulty at the facility. R1 explained that he had gout, cellulitis and wounds on his feet which impacted his ability to participate with physical therapy. During an observation on 11/13/24 at 1:14 PM, R1 was lying in bed on a standard mattress, a standard pillow under his feet, however, the pillow had compressed and R1's feet were resting on the mattress. RN C assembled supplies and explained the dressing change to R1, who agreed to the observation. RN C removed the dressings, dated 11/11/24, on R1's left foot which were saturated with serosanguinous drainage. Three separate areas were noted along the lateral aspect of R1's left foot and heel which presented as unstageable wounds due to eschar covered most of the wound beds, with slough at the rolled edges. RN C cleansed and redressed each wound. RN C then removed the dressing on R1's right heel, dated 11/11/24, with moderate serous exudate present. The right heel wound was also unstageable due to the presence of eschar and slough. R1 winced in pain during the procedure. It was noted that the sheet at the foot of the bed was streaked with what appeared to be dried bloody/serous drainage. During the observation of wound care on 11/13/24 at 1:14 PM, R1 reported that he tried to elevate his feet off the bed, but the pillow kept slipping away. R1 again reported he was having a hard time working with physical therapy due to the wounds on his feet which was a frustrating set-back as he was looking forward to going home. During an observation on 11/13/24 at 3:27 PM, R1 was observed resting in bed, his heels resting directly on the mattress. Review of a Skin & Wound - Total Body Skin assessment dated [DATE] (the day after R1 admitted to the facility) reflected R1's did not have any wounds. Review of Progress Notes dated 9/25/24, documented by CNS A reflected Per nursing, back wound noted, and excoriation noted on bottom. For back care, cleanse with wound cleanser daily and cover with border gauze. For excoriation: do pericare daily with mild soap and water, apply zinc barrier cream BID (twice a day) and PRN (as needed). Swelling persists in LLE (left lower extremity). The extremity appears shiny and swollen with redness discoloration noted near the posterior malleolus. Encouraged patient to elevate. Continue with torsemide (diuretic) 20 mg (milligrams) daily. As previously mentioned, patient states he thinks he has gout but has never been evaluated by his primary care provider for this condition. Symptoms do appear to be consistent with gout diagnosis. If no improvement noted with consistent elevation, will consider trialing of indomethacin or colchicine and monitor for improvement. Uric acid level and BMP (basic metabolic panel) level due on 9/30 (2024). Will continue to monitor. Review of a Skin & Wound - Total Body Skin assessment dated [DATE] (13 days after the previous assessment) reflected R1 had 4 New Wounds. Review of a Nurses Notes dated 9/26/24 reflects, (R1) has four new wounds to his feet. To his left heel he had a popped (open) blister that measures 3.7 x 2.0 cm (centimeters). He has blisters on the lateral side of his right foot that go from heel to toes. The heel measures 4.9 x 3.5, mid lateral foot is 3.3 x 2.2 cm and toward the toes was 2.2 x 2.2 cm. (Note: this progress notes incorrectly identified the location of R1's wounds, clarified with CNS A during an interview on 11/14/24 at 8:30 AM. R1 has one wound on his RIGHT heel, and three wounds on his LEFT foot.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Progress Notes dated 9/27/24 documented by Clinical Nurse Specialist (CNS) A reflected (R1) seen for a possible gout (a type of arthritis that occurs when the body has too much uric acid, which causes crystals to form in the joints. Gout causes sudden, severe pain, swelling, redness, and warmth in the affected joint) flare, pain, and PT/OT (Physical Therapy/Occupational Therapy) tolerance. Patient stated he is having a hard time working with therapy because of his chronic left foot and left knee pain. Patient stated it was gout today and not arthritis. Had at length conversation to clarify if patient had ever formally been diagnosed with gout. Patient stated no. LLE (left lower extremity) does appear consistent with gout with swelling, erythema (redness), and shiny skin. Some blisters noted on LLE, hard to distinguish if blisters are related to tophi (a deposit of uric acid crystals that form under the skin in joints, tendons, and soft tissues). Will continue to monitor and order wound care . The progress note did not mention the opened blister on the right foot. Review of R1's September 2024 Treatment Administration Record (TAR) reflected the order L (left) foot blister care: daily for night shift. Cleanse foot daily with mild soap and water. If blisters are intact apply skin prep. If not intact, apply A & D and cover with gauze. May apply roll gauze to keep in place every night shift for L foot blister care. -Start Date- 9/28/24 11:00 PM. Further review of the September 2024 TAR did NOT reflect a treatment order to treat the open blister on R1's right foot. Review of a Skin & Wound - Total Body Skin assessment dated [DATE] reflected R1 had 3 New Wounds. No further documentation related to the new wounds were found in the clinical record. Review of a Progress Notes dated 10/01/24 documented by CNS A reflected Foot examined. 1+ swelling noted, nonpitting, three blood blisters present and intact. The note indicates R1 is still being evaluated for gout and is having trouble tolerating therapy due to pain in foot. The progress note does not address the condition of R1's right heel. Review of Progress Notes dated 10/03/24 documented by CNS A reflects New unstageable pressure wound found on R (right heel). Unsure of origin. Slough (dead tissue that can impede wound healing and increase risk of infection) and Eschar (a collection of dry, dead tissue within the wound) present at base. Wound consult updated. Wound care ordered as Right heel pressure ulcer care: Cleanse daily with wound cleanser, apply calcium alginate cut to fit area, and cover with bordered gauze daily. Date and initial. Weight bearing as tolerated for RLE (right lower extremity) to promote wound healing. Wound (wound care consultant) to see 10/07 (2024) . Review of the EMR reflected R1 signed a consent to be treated by the wound care consultant upon admission as evidenced by a Wound Care Patient Consent Form document signed by R1 on 9/12/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Progress Notes dated 10/28/24 for Wound Care indicates Wound care consulted for follow-up, evaluation, and treatment on bilateral foot wounds. The note revealed 1. (1) Right Heel Pressure Unstageable - This wound measures 3.18 x 1.84 cm with a depth of 0.1 cm. This wound is full thickness. There is a moderate amount of serous drainage from the area. Wound bed consists of 50% eschar and 50% slough tissue. Edges are attached and there is no tunneling, undermining, or odor. The surrounding tissue is fragile but without redness, warmth, swelling, pain induration or sign of infection. 2. (2) Left Lateral Midfoot Blister - This wound measures 12.48 x 2.68 centimeters with a depth of 0.1 centimeters. This wound is partial thickness. There is a moderate amount of serosanguinous drainage from this area. Wound bed consists of 90% epithelial and 10% granulation tissue. Edges are attached and there is no slough, eschar, tunneling, undermining or odor. The surrounding tissue is fragile but without redness, warmth, swelling, pain, induration, or sign of infection. The wound care note does not specify R1 had three blistered areas on the left foot as had been previously documented. This note indicates the first time R1 is evaluated by the wound care consultant, three weeks from the time CNS A indicated R1 would be seen. Review of Nurses Notes dated 10/29/24 reflects Wound an R (right) heel noted to have strong foul odor and excessive amount of purulent drainage. (R1) c/o (complains of) chills. Res (resident) noted to have fever, elevated pulse, and BP (blood pressure) lower than baseline. On-call provider notified and orders were obtained for midodrine (treats low blood pressure) and Rocephin (broad-spectrum antibiotic). Orders administered. On-call provider then told this nurse that she would like the res sent to ED (Emergency Department) for eval (evaluation). Res refusing to go to the hospital at this time-on-call provider notified of refusal. Review of Progress Notes dated 10/30/24 reflected .Patient is lethargic. Blood pressure is still running in 90s this morning. Educated patient that he did meet all the criteria for sepsis and is may have been beneficial for patient to go to hospital for further evaluation. R heel wound examined, purulent and foul odor drainage noted. Wound base with eschar spreading around site. I will order a wound culture and empiric antibiotic treatment until wound culture results. Per up-to-date recommendations, empiric antibiotic therapy stated into Amoxicillin-Pot Clavulanate Oral Tablet 875-125 MG BID for 5 days and doxycycline 1-mg tablet BID for 5 days or longer pending result of wound culture. As patient was meeting criteria for sepsis, the benefit of starting empiric antibiotic therapy outweighs the risk to prevent hospitalization or further deterioration. Review of an Order Recap Report for all R1's orders from admission to 11/13/2024 did not reflect a wound culture had been ordered. During an interview on 11/14/24 at 8:30 AM, CNS A reported she had been following R1's wounds and acknowledged the first order in place to treat the blister was for closed blisters, not open wounds. CNS A said she did not know R1 had an open wound on the right heel. CNS A said when R1 developed signs and symptoms of sepsis she was very worried and wanted R1 to go to the hospital. When R1 refused hospitalization , CNS A ordered medication to support his blood pressure, an empiric antibiotic and wanted a wound culture to ensure the antibiotic therapy ordered was appropriate. CNS A said she kept looking for the wound culture results, and it was discovered the wound culture was never ordered or obtained. CNS A said she was concerned R1 may have MRSA (Methicillin-resistant Staphylococcus aureus) which would not have been treated with the antibiotic ordered. CNS A reported she did not know why the wound care consultant did not evaluate, treat and monitor R1's wounds until 10/28/24 (three weeks after the consultation was requested). According to CNS A, regardless of how the wounds developed, the lack of pressure reducing interventions did not promote healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Skin & Wound Evaluation reports, dated 11/11/2024 (entered 2 weeks after the wounds were assessed) reflected R1's wounds were first evaluated on 10/28/24. As of 11/14/2024 NO other wound measurements and descriptions were found in the EMR. The wounds were described as follows: 1. Left lateral midfoot, pressure, unstageable: obscured full-thickness skin and tissue loss due to slough and/or eschar, in house acquired; Length 2.2 cm, Width 1.2 cm, Depth 0.1 cm; wound bed-slough, 50% of wound filled, eschar, 50% of wound filled. Additional Care specified R1 needed Heel Suspension/Protection device, mattress with pump, nutritional/dietary supplementation. 2. Left Lateral Foot, pressure, unstageable: obscured full-thickness skin and tissue loss due to slough and/or eschar, in house acquired; Length 3.8 cm, Width 2.7 cm, Depth 0.1 cm; Wound bed-slough 10% of wound filled, Eschar, 50% of wound filled. Additional Care specified R1 needed Heel Suspension/Protection device, mattress with pump, nutritional/dietary supplementation. 3. Left Lateral Foot, Distal, pressure, unstageable: obscured full-thickness skin and tissue loss due to slough and/or eschar, in house acquired; Length 1.0 cm, Width 0.9 cm, Depth 0.1 cm; Wound bed 100% eschar. Additional Care specified R1 needed Heel Suspension/Protection device, mattress with pump, nutritional/dietary supplementation. 4. Right Heel, pressure, present on admission (this is incorrect, as evidenced by the admission assessment and subsequent total body skin assessments); Length 2.0 cm, Width 1.4 cm, Depth 0.2 cm, wound bed-slough 50%, eschar 50%. Additional Care specified R1 needed Heel Suspension/Protection device, mattress with pump, nutritional/dietary supplementation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 29073 This citation pertains to intake MI00147718 Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for one resident (Resident #1) out of 4 residents reviewed for infection control. Findings: Review of a policy Enhanced Barrier Precautions effective 4/1/2024 reflects It is the intent of this facility to use Enhanced Barrier Precautions (EBP) in addition to Standard Precautions for preventing the transmission of CDC targeted multidrug-resistant organisms (MDROs). Enhanced Barrier Precautions are indicated for residents with any of the following: 1) infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO and should remain in place for the duration of a resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that place them at higher risk. The policy specified that signage would be placed on the door to indicate the resident required EBP and Personal Protective Equipment (PPE) would be readily available to staff. EBP are to be implemented for high-contact resident care. During an observation on 11/13/24 at 10:50 AM, No signage or PPE were available on Resident #1 (R1) door or in the resident's room. Certified Nurse Aide (CNA) D and an unknown CNA entered R1's room to assist the resident to the commode. Neither CNA donned the required PPE for the high contact resident care. During an observation on 11/13/24 at 1:14 PM, R1 was lying in bed on a standard mattress, a standard pillow under his feet, however, the pillow had compressed and R1's feet were resting on the mattress. Registered Nurse (RN) C assembled supplies and explained the dressing change to R1, who agreed to the observation. RN C removed the dressings, dated 11/11/24, on R1's left foot which were saturated with serosanguinous drainage. Three separate areas were noted along the lateral aspect of R1's left foot and heel which presented as unstageable wounds due to eschar covered most of the wound beds, with slough at the rolled edges. RN C cleansed and redressed each wound. RN C then removed the dressing on R1's right heel, dated 11/11/24, with moderate serous exudate present. The right heel wound was also unstageable due to the presence of eschar and slough. R1 winced in pain during the procedure. It was noted that the sheet at the foot of the bed was streaked with what appeared to be dried bloody/serous drainage. RN C donned gloves for the procedure but did not don a gown as would be required for a resident who needed EBP. Review of an Order Recap Report for the date range 9/01/2024-11/13/2024 did not reflect EBP had been ordered for R1. Review of a Care Plan initiated on 9/12/2024 did not reflect R1 required EBP. During an interview on 11/13/24 at 2:27 PM, RN C reported she was new to the facility and had heard about EBP but did not know EBP's were needed for the wound care.