STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365379	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Walden Park	5700 Karl Road Columbus, OH 43229

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to appropriately investigate a resident incident. This affected one (Resident #301) of three resident incidents reviewed. The census was 219. Findings Include: Resident #301 was admitted to the facility on [DATE]. His diagnoses were chronic obstructive pulmonary disease, chronic kidney disease, asthma, acute respiratory failure, hypotension, atrial fibrillation, anemia, vascular dementia, congestive heart failure, epilepsy, dorsalgia, alcohol abuse, diverticulitis, suicidal ideation, hydronephrosis, restlessness and agitation, nicotine dependence, sleep apnea, polyneuropathy, and depression. Review of his minimum data set (MDS) assessment, dated 08/28/24, revealed he had a severe cognitive impairment. Review of Resident #301 progress notes and fall investigation, dated 10/05/24, revealed he had an unwitnessed fall while in the facility. Because he had an unwitnessed fall, the facility started neurological checks. Review of the neurological checks, dated 10/05/24 to 10/06/24, revealed they were completed as required, but on 10/06/24 at the 7:30 P.M. check, the documentation stated he was out of the facility. Review of Resident #301 progress notes, dated 10/06/24, revealed he was found by local law enforcement by a liquor store, smelled of alcohol and was acting as if he were intoxicated, so he was taken to the local hospital for interventions. He was sent back to the facility later that evening, where he ate a snack and went to bed. There was no documentation to support the facility knew he went out of the facility and to the liquor store. Review of Resident #301 medical records found no evidence of an investigation and/or incident review of Resident #301 being out of the facility, and then being treated for intoxication by the local hospital. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #500 on 10/29/24 at 8:43 A.M. revealed she arrived to the facility around 7:00 P.M. on 10/06/24. She stated she went to see Resident #301 for his neuro-check around 7:30 P.M., but she did not see him. She conformed she wrote out of the facility on his neurological check at that time, but she did not know if he was really out of the facility. Then, between 8:15 P.M. and 8:30 P.M., she went to find him again to give his medication; he still wasn't found. She asked some of his friends if the knew where he was; they didn't. Around that same time, the facility received a call from the hospital that Resident #301 was at their building, being treated for intoxication. She confirmed she did not know he was out of the facility until the hospital called. Interview with Director of Nursing on 10/29/24 at 9:30 A.M. confirmed they did not complete an investigation for Resident #301 being out of the facility. She confirmed she did not know when he left, how long he had been out of the facility, did not interview any of the staff that worked during the times that he allegedly left, and did not interview Resident #301 to gather information about the incident. This was an incidental finding related to complaint number OH00158728.