| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365379 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Laurels of Walden Park | 5700 Karl Road<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008<br><br>Based on observations, medical record review, and staff interviews, the facility failed to monitor bruising and bleeding risk for a resident on an anticoagulant. This affected one resident (Resident #45) out of three residents reviewed for anticoagulant medications, and had the potential to affect 48 residents that the facility identified as being on anticoagulant medication. The facility census was 205 residents.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #45 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, dependence on renal dialysis, mood disorder, anemia, anxiety disorder and heart failure.<br><br>Review of Resident #45's Minimum Data Set (MDS) assessment dated [DATE] revealed that her Brief Interview for Mental Status (BIMS) was 15, indicative of intact cognition. Review of her MDS also revealed that she was receiving anticoagulant medication.<br><br>Review of Resident #45's physician orders revealed that effective 01/18/25, she had physician orders for Apixaban (an anticoagulant medication) 5 milligrams (mg) one tablet by mouth twice daily.<br><br>Review of Resident #45's care plan dated 01/27/25 revealed that she was at risk for alteration in hematological status related to anemia and anticoagulant side effects. Interventions, effective 01/27/25, were to administer medications as ordered and observe for side effects of the medication, and to observe for signs of increased bleeding such as bruising.<br><br>Observation on 04/10/25 at 8:40 A.M. of Resident #45's skin revealed that she had maroon, gray-brown and yellow bruising on her bilateral forearms and gray-brown and yellow bruising on her lower right extremity.<br><br>Interview on 04/10/25 at 11:04 A.M. with Registered Nurse (RN) #264, who was Resident #45's assigned nurse for the day, revealed that he was unaware of bruising to Resident #45's bilateral forearms and lower right ankle. Further interview confirmed the presence of bruising on Resident #45's lower right ankle and bilateral forearms, and that the resident was receiving anticoagulant medication as ordered. He stated that bruising should be monitored for residents on anticoagulant medication.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the Director of Nursing (DON) on 04/10/25 at 11:06 A.M. confirmed there was no documented evidence of an order to monitor Resident #45's bruising in the medical record, nor did the wound nurse, consulted by the DON, have any evidence of monitoring Resident #45 for bruising.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00164173. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008<br><br>Based on medical record review, staff interview, and review of facility policy, the facility failed to investigate or assess a resident after a significant weight gain. This affected one resident (Resident #208) out of four residents reviewed for weight changes. The facility census was 205 residents.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #208 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, encounter for tracheostomy, intracerebral hemorrhage, end stage renal disease, dependence on renal dialysis, dysphagia, and hemiparesis.<br><br>Review of Resident #208's nutrition care plan dated 11/05/24 revealed he was at risk for nutritional decline. An intervention was to observe and evaluate weight and weight changes.<br><br>Review of Resident #208's Minimum Data Set (MDS) assessment on 02/20/25 revealed that he was cognitively impaired.<br><br>Review of Resident #208's weight record revealed that he weighed 169.1 pounds (lbs) on 03/06/25 and he weighed 181.9 lbs on 04/03/25, indicating a significant weight gain of 7.6 percent (%) in less than 30 days.<br><br>Review of Resident #208's progress notes from 04/03/25 to 04/09/25 revealed that they were silent for any charting related to the weight gain, including acknowledgement/identification of the weight gain or an assessment of the weight gain.<br><br>Review of Resident #208's progress notes further revealed that he was sent to the hospital on 04/09/25 related to a change in condition.<br><br>Interview with Dietitian #440 on 04/09/25 at 5:13 P.M. revealed that on 04/03/25 she input the weight for Resident #208 into the computer, but did not notice the weight change at the time. Further interview confirmed that residents with significant weight changes should be re-weighed within two days. Dietitian #440 confirmed that the weight gain for Resident #208 had not been assessed or documented.<br><br>Interview with the Director of Nursing (DON) on 04/10/25 at 3:06 P.M. revealed that the dietitian was responsible for monitoring the weekly weights, not the nursing staff.<br><br>Review of a facility policy titled Weight Management dated 09/22/23 revealed that residents will be monitored for significant weight change on a regular basis. The registered dietitian and DON are responsible for coordination of an interdisciplinary approach to managing the process for prediction, prevention, treatment, monitoring and calculation of significant weight loss and or gain. Reweighs will be initiated for a five-pound variance if the resident is over 100 lbs. Reweighs will be done within 48 to 72 hours.<br><br>(continued on next page) |

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| | 365379 | A. Building<br>B. Wing | 04/10/2025 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This deficiency represents non-compliance investigated under Complaint Number OH00164173. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059<br><br>Based on observations, medical record review, resident interview, staff interviews, review of admission checklists and review of facility policy, the facility failed to reconcile admission orders with a resident's previous medication orders to provide required eye drops per resident's expectations and physician orders. This affected one resident (Resident #156) out of three residents reviewed for medication administration. The facility census was 205 residents.<br><br>Findings Include:<br><br>Review of the medical record revealed Resident #156 was admitted on [DATE] readmitted on [DATE] with diagnoses that included end stage renal disease, status post cadaver - donor kidney transplant, dependence on renal dialysis, congestive heart failure, presence of cardiac pacemaker, immunodeficiency due to drugs, type two diabetes mellitus with diabetic neuropathy, depression, chronic pain, and sarcoidosis.<br><br>Review of the physician orders dated 03/23/25, prior to the hospitalization , revealed Resident #156 was to receive Brimonidine Tartrate Ophthalmic Solution 0.2 percent (%) with instructions to administer one drop to each eye twice per day.<br><br>Review of the hospital after visit summary (AVS) dated 03/31/25 revealed Resident #156 was to receive Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) with instructions for one drop in each eye twice per day per the skilled nursing facility (SNF). Additional instructions stated that the medication was to be administered once per day, though the administration time chart had a check mark indicating to administer one drop in each eye in the morning and evening.<br><br>Review of the readmission medication orders, dated 03/31/25, for Resident #156 revealed orders for Brimonidine Tartrate Ophthalmic Solution 0.2 % one drop to each eye daily.<br><br>Review of the Medication Administration Record (MAR) for April 2025 revealed Resident #156 received Brimonidine Tartrate Ophthalmic Solution 0.2 % one drop to each eye daily for glaucoma from 04/01/25 to 04/09/25.<br><br>Interview on 04/08/25 at 11:45 A.M. with Resident #156 revealed he was supposed to get eye drops and it was supposed to be from the purple bottle twice a day, but now he was getting it once a day. He revealed it was not a hospital order, it was a veteran's administration (VA) order and he would have to go to the VA and tell them that the facility didn't give it him properly.<br><br>Interview on 04/10/25 at 8:31 A.M. with Licensed Practical Nurse (LPN) #294 confirmed that when a resident went to the hospital and was gone for more than 24 hours, the orders were discontinued. She stated when the resident returned, the medication orders on the AVS were verified with the physician or nurse practitioner and new orders were entered into the computer.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 04/10/25 at 11:40 A.M. with LPN #294 confirmed Resident #156's hospital AVS, under the heading should continue taking these medications read that Resident #156 should continue to take Brimonidine 0.2% solution with instructions to place one drop in both eyes twice daily per the SNF medication list. The next line read to instill one drop of the medication in both eyes one time per day. The AVS sections indicating the dose and time of day for the medication to be given had a check mark indicating one drop of the medication was administered in the morning in the evening. LPN #294 reviewed the order and stated Resident #156 had been receiving eye drops twice daily prior to the hospitalization , and she also stated that the resident knew his medications. LPN #294 verified that the morning and evening checkmarks indicated that the medication was still to be twice a day, so if she had been the nurse to readmit the resident, she would have verified it with the nurse practitioner when verifying admission orders. LPN #294 also stated the VA physician had just called with the order for Brimonidine 0.2% solution with instructions to administer one drop in both eyes twice daily.<br><br>Review of the Licensed Nurse Admission Checklist dated January 2014 revealed step five on the checklist was to notify the physician and verify orders. Step six was that admission orders were reconciled and communicated to the pharmacy.<br><br>Review of the policy Medication Administration revised 10/17/23 revealed medications are administered in accordance with the written orders of the attending physician. If a dose is inconsistent with the resident's age and condition or a medication order is inconsistent with the residents current diagnosis or condition, staff are to contact the physician for clarification prior to administration of the medication. The interaction with the physician would be documented in the progress notes and elsewhere in the medical record, as appropriate.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00164244, Complaint Number OH00164173, and Complaint Number OH00164031. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008<br><br>Based on medical record review, staff interviews, and review of facility policy, the facility failed to monitor side effects of a resident on antipsychotic medications. This affected one resident (Resident #106) out of three residents reviewed for antipsychotic medications, and had the potential to affect 47 residents that the facility identified as being on antipsychotic medication. The facility census was 205 residents.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #106 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease, schizophrenia, hypothyroidism, dementia, and drug induced dyskinesia.<br><br>Review of Resident #106's care plan dated 05/08/19 revealed that she was at risk for adverse reaction and side effects related to receiving psychotropic medication due to the resident taking an antipsychotic for schizophrenia. Interventions included observing for side effects related to taking antipsychotic medications such as sedation, headaches, dizziness, diarrhea, anxiety, dystonia, Parkinsonism, restlessness, blurred vision, constipation, dry mouth, tardive dyskinesia and to report abnormal findings to the physician.<br><br>Review of Resident #106's medication orders revealed effective on 07/29/19, she had physician orders for Paliperidone (an antipsychotic medication) Extended Release 6 milligrams (mg) twice daily.<br><br>Review of Resident #106's Minimum Data Set (MDS) assessment dated [DATE] revealed that her Brief Interview for Mental Status (BIMS) was 09, indicative of moderately impaired cognition.<br><br>Review of Resident #106's January 2025 through April 2025 orders, Medication Administration Record (MAR), Treatment Administration Record (TAR), progress notes, and tasks revealed no documented evidence that the resident was being monitored for antipsychotic medication side effects on a daily basis.<br><br>Interview with the Director of Nursing (DON) on 04/09/25 at 12:39 P.M. revealed that for antipsychotic medications, her expectation would be that even if it was an older order, she would expect to see monitoring for side effects of the medication on a daily basis in the medical record.<br><br>Interview with the Assistant Director of Nursing (ADON) #250 on 04/09/25 at 12:40 P.M. confirmed that the monitoring for the side effects of antipsychotic medications should be documented in the resident's medical record on a daily basis. She stated that the side effect documentation would be located in the MAR or TAR. Further interview with ADON #250 confirmed that Resident #106 was missing daily documentation of monitoring for side effects of her antipsychotic medication.<br><br>Review of the facility policy titled Behavior Management updated 04/20/23 revealed that describing behaviors such as agitation, restlessness and fidgeting can aide in identifying medication side effects.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This deficiency represents non-compliance investigated under Complaint Number OH00164173. |