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	08/13/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure residents advance directives were readily available to facility staff and Emergency Medical Service (EMS) personnel. This affected four residents (#17, #129, #198, and #236) of the 51 residents reviewed for advance directives. The facility census was 209. Findings included: 1. Closed record review for Resident #236 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included dementia with severe psychotic disturbance, atrial fibrillation, and repeated falls. Review of the admission Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #236 was severely impaired cognition. Review of the physician's order, dated [DATE], revealed Resident #235's code status was Do Not Resuscitate Comfort Care Arrest (DNRCC-A) and Do Not Intubate (DNI). Review of the facility's advance directive form, signed by Resident #236's son on [DATE], revealed the resident was to not have Cardiopulmonary Resuscitation (CPR) initiated in the event the resident's heart or breathing stopped. The resident was not to be transported to the hospital for emergency intervention. The form was not signed by the physician. No other advance directive forms were present in the resident's electronic health record. Review of the progress note dated [DATE] at 8:10 P.M. revealed Resident #236's oxygen saturation level was 66 percent. Emergency 9-1-1 was called and resident's son notified. The progress note dated [DATE] at 8:29 P.M. revealed emergency medical services (EMS) personnel in facility currently performing CPR. Nurse Practitioner notified for verbal order for no resuscitation and medics unable to take verbal order over the phone due to needing order signed by the attending. Medics continue working on resident at this time. The progress note dated [DATE] at 9:28 P.M. revealed the resident's condition had changed upon their arrival. CPR was performed by paramedics on site and a pulse was successfully restored. Resident transported to hospital. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EMS run report, dated [DATE], revealed EMS dispatched to facility for difficulty breathing. EMS entered the room and found Resident #236 pulseless and without respirations. Due to staff inability to provide a valid DNR, life saving efforts were initiated. Resident was moved to the floor and compressions were initiated. Initial heart rhythm showed Pulseless Electrical Activity (meaning the heart had electrical activity but no detectable pulse). Advanced Life Support continued. Upon next rhythm check possible Ventricular Fibrillation observed. Emergent transport initiated, resident maintained pulses and was monitored closely throughout transport. Arrived at hospital and transferred care to hospital staff. Review of the hospital visit note, dated [DATE], revealed Resident #236 presented to the hospital in cardiac arrest from skilled nursing facility. Per EMS, resident had a DNRCC but facility unable to find the paperwork and there was no family. Life saving measures continued at the hospital and the resident was revived. Family arrived and confirmed the resident was DNRCC. Care was de-escalated and the resident died quietly with multiple family at bedside. Telephone interview with Registered Nurse (RN) #280 on [DATE] at 2:12 P.M. confirmed Resident #236 had a change in condition around the change of shift on [DATE]. RN #280 confirmed Resident #236 went unresponsive and EMS were called. RN #280 confirmed the resident had an order for DNRCC-A code status but the DNR paperwork signed by the physician could not be located. RN #280 confirmed EMS personnel arrived and began CPR, obtained a heartbeat for the resident, then took him to the hospital. 2. Record review for Resident #17 revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, and atrial fibrillation. Review of the significant change MDS assessment dated [DATE] revealed Resident #17 was mildly impaired cognition. Review of the active care plan, dated [DATE], revealed Resident #17 was full code status. Interventions included code status to be reviewed upon readmission, quarterly, with significant changes, and at the desire of the resident or responsible party. Review of the physician's order, dated [DATE], revealed Resident #17 was to be DNRCC-A. Additional record review for the resident revealed no signed DNR paperwork was available for review in the resident's electronic health record. Observation and interview with Unit Manager #110 on [DATE] at 8:10 A.M. confirmed there was a code status book located at each nurse's station. RN Unit Manager #110 confirmed there was to be DNR paperwork signed by the physician for each resident who wished to be DNR code status. Unit Manager #110 confirmed there was not signed DNR paperwork in the code status book for Resident #17. Record review and interview with Unit Manager #110 on [DATE] at 8:30 A.M. confirmed there was not signed DNR paperwork located in the electronic health record of Resident #17. 3. Review of the medical record for Resident #129 revealed an admission date of [DATE]. Diagnoses included cerebral atherosclerosis and type II diabetes mellitus with hyperglycemia. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #129 was cognitively impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #129’s medical chart revealed signed DNR paperwork in electronic medical record (EMR). Review of Resident #129’s physician orders revealed he has active no CPR/DNR order. Observation of the code status book on Resident #129’s nursing unit revealed there was not a signed DNR copy in the code status binder for Resident #129. Interview with Unit Manager #130 on [DATE] at 8:12 A.M. confirmed there was a code status book located at each nurse's station. Unit Manager #130 confirmed there was not a copy of signed DNR paperwork in the code status binder for Resident #129. 4. Review of the medical record for Resident #198 revealed an admission date of [DATE]. Diagnoses included disorder of congestive heart failure and dementia. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #198 was cognitively intact. Review of Resident #198’s physician orders revealed she had an advanced directive code status of DNRCC-A, which indicated Resident #198 did not wish for resuscitative measures to be initiated if they experienced cardiac or respiratory arrest; however, until such an arrest occurs, they would receive full medical treatment. Observation of the code status book on Resident #198’s nursing unit revealed there was not a DNRCC-A signed form in the code status binder for Resident #198. Interview with Registered Nurse (RN) #130 on [DATE] at 9:01 A.M. confirmed there was no advanced directives sheet in the code status binder for Resident #198. RN #130 confirmed if a resident was to code, they would need to be able to pull up the advanced directives in the binder to confirm the resident’s code status. Review of the facility policy titled Ohio Advance Directive effective [DATE] revealed the facility will determine whether the resident's physician issued a DNR Order in another setting and whether the resident would like a DNR Order issued while in the facility. Copies of all advance directives will be obtained from the resident and/or family and placed in the medical record. If applicable, a DNR Order will be obtained from the residents physician and placed in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00167220 (1260023).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident, guardian and staff interviews, and review of facility policy, the facility failed to maintain a safe, clean and homelike environment in resident rooms. This affected two (Resident #18 and #70) of seven residents reviewed for homelike environment. The facility census was 209 residents. Findings include: Record review revealed Resident #18 was admitted to the facility on [DATE]. Resident #18 had been appointed a guardian on 01/13/25. Interview with the guardian for Resident #18 on 08/04/25 at 1:54 P.M. stated the sink in Resident #18's room had been leaking and the faucet that been loose since March 2025. She stated she had notified the facility of this concern and it has never been fixed. Observations on 08/04/25 at 2:48 P.M., 08/07/25 at 8:54 A.M. and 3:46 P.M., and on 08/11/25 at 8:26 A.M. revealed Resident #18's sink faucet was loose and dripping. The baseboard, approximately three feet in length, behind the toilet was separated from the wall, revealing a dark brown and black surface underneath. An interview with the roommate of Resident #18, Resident #70, on 08/07/25 at 8:54 A.M. stated he used the sink when he was up in his wheelchair. He stated the had told the facility about the loose, leaky sink faucet and it has never been fixed. An interview with Registered Nurse (RN) #330 on 08/11/25 at 8:23 A.M. stated he was aware of the loose leaking sink in Resident #18's room but not aware about the baseboard that was separated from the wall. An interview with Maintenance Workers #801 and #821on 08/11/25 at 8:26 A.M. confirmed Resident #18's sink faucet was loose, leaking and that the baseboard was separated from the wall revealing a dark surface area. They stated that they would fix the baseboard and sink. An interview with Housekeeper #591 on 08/11/25 at 10:49 A.M. revealed she was aware of the separated baseboard and the loose and leaking sink faucet in Resident #18's room and she had reported it to her supervisor. Review of the undated facility policy titled Daily Cleaning of Guest Rooms revealed housekeeping is to report any items that need repaired to the maintenance department. Review of the facility policy titled Federal and State-Resident Rights and Facility Responsibilities dated 05/14/24 revealed the resident has the right to a safe, clean, comfortable and homelike environment. Housekeeping and maintenance services will maintain a sanitary, orderly and comfortable interior.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, policy review, and review of the facilities Self-Reported Incidents (SRI), the facility failed to timely report allegations of physical and verbal abuse and injuries of unknown origin to the State Survey Agency. This affected three (#6, #72, and #183) of eight residents reviewed for abuse. The facility census was 209. Findings include: 1. Review of the medical record for Resident #6 revealed the resident was admitted on [DATE]. Diagnoses included alcoholic cirrhosis of the liver without ascites, permanent atrial fibrillation, chronic obstructive pulmonary disease (COPD), and schizoaffective disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had severe cognitive impairment. Review of the nursing notes dated 12/23/24 documented an interdisciplinary team (IDT) meeting regarding an incident of physical aggression received on 12/21/24. The resident was observed with a bleeding nose and stated, He punched me. All involved parties were made aware, an assessment was completed by the floor nurse, and the immediate intervention was to move the resident to another room. The IDT agreed with the room change. The nursing notes dated 12/31/24 at 8:30 A.M. documented the resident was found with bruising and skin tears to the face, blood on the face and bathroom floor, feces smeared on the body, and one gripper sock on foot with urine on the floor. The resident stated, I probably hit my head. Vital signs were stable. The nursing notes dated 01/02/25 documented an IDT meeting was held to address the bruising and skin tears. The injury was consistent with contact with the bathroom door, and a night light was ordered for the resident’s room. Review of the facilities SRIs from 12/21/24 through 01/02/25 revealed there were no SRIs reported for the allegation of physical abuse for Resident #6 for the incident on 12/21/24 and there was no SRI filed for the injuries of unknown origin on 12/31/24. Interview on 08/07/25 at 11:15 A.M. with the Administrator confirmed the facility did not submit an SRI involving Resident #6 for the physical abuse incident on 12/21/24 and injury of unknown origin on 12/31/24. At 2:07 P.M., the Administrator confirmed an SRI was submitted approximately eight months late following discussion during the survey. 2. Record review for Resident #72 revealed the resident was admitted to the facility on [DATE]. Diagnoses included bipolar disorder, intellectual disabilities, and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 had moderately impaired cognition. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note dated 06/27/25 revealed Resident #183 was cursing out Resident #72 calling her a 'fat expletive'. This nurse went to investigate the noise and Resident #183 called the nurse an expletive as well. Resident #183 cursing kept going on even when this nurse intervened. Resident #183 made Resident #72 cry. Review of the facility SRI control number 262200, dated 06/30/25, revealed Resident #183 was witnessed by staff screaming profanity words at Resident #72. This SRI was filed three days after the verbal abuse allegation occurred. The nursing progress note dated 07/30/25 revealed Resident #183 was verbally abusive towards residents in the dining area. Resident #183 used words like 'expletive you' and 'expletive' prompting immediate intervention from this nurse and the day shift nurse. Despite being asked to refrain from using such inappropriate language, Resident #183 got more angry and escalated his behavior using even more explicit language. Resident #183 eventually stopped and was escorted to his room to rest. There was no SRI filed with the Stage Survey Agency (SA) by the facility for the allegation of verbal abuse by Resident #183 on 07/30/25. Interview with the Administrator on 08/11/25 at 10:45 A.M. confirmed an SRI for the allegation of verbal abuse which occurred on 06/27/25 between Resident #183 and Resident #72 was not completed until 06/30/25, three days after the incident occurred. The Administrator additionally confirmed no SRI had been completed for the allegation of verbal abuse by Resident #183 on 07/30/25. Review of the facility policy titled Abuse Prohibition, effective 10/14/22, revealed the Administrator or designee will notify any State or Federal agencies of allegations per state guidelines two hours if abuse allegation or serious injury; all other not later than 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, and review of a facility policy, the facility failed to ensure allegations of verbal and physical abuse and injuries of unknown origin were thoroughly investigated. This affected three (#6, #72 and #183) of eight residents reviewed for abuse. The facility census was 209. Findings include: 1. Record review for Resident #72 revealed the resident was admitted to the facility on [DATE]. Diagnoses included bipolar disorder, intellectual disabilities, and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 had moderately impaired cognition. Review of the nursing progress note dated 06/27/25 revealed Resident #183 was cursing out Resident #72 calling her a 'fat expletive'. This nurse went to investigate the noise and Resident #183 called the nurse an expletive as well. Resident #183 cursing kept going on even when this nurse intervened. Resident #183 made Resident #72 cry. Review of the facilities investigation revealed it was not initiated until three days later on 06/30/25. The nursing progress note dated 07/30/25 revealed Resident #183 was verbally abusive towards residents in the dining area. Resident #183 used words like 'expletive you' and 'expletive' prompting immediate intervention from this nurse and the day shift nurse. Despite being asked to refrain from using such inappropriate language, Resident #183 got more angry and escalated his behavior using even more explicit language. Resident #183 eventually stopped and was escorted to his room to rest. The facility was unable to provide any investigation into the allegation of verbal abuse by Resident #183 on 07/30/25. Interview with the Administrator on 08/11/25 at 10:45 A.M. confirmed the investigation of the allegation of verbal abuse involving Residents #183 and #72 which occurred on 06/27/25 was not initiated until 06/30/25, three days after the incident occurred. The Administrator additionally confirmed no investigation had been completed for the allegation of verbal abuse by Resident #183 on 07/30/25. 2. Review of the medical record for Resident #6 revealed the resident was admitted on [DATE]. Diagnoses included alcoholic cirrhosis of the liver without ascites, permanent atrial fibrillation, chronic obstructive pulmonary disease (COPD), and schizoaffective disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had severe cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing notes dated 12/23/24 documented an interdisciplinary team (IDT) meeting regarding an incident of physical aggression received on 12/21/24. The resident was observed with a bleeding nose and stated, He punched me. All involved parties were made aware, an assessment was completed by the floor nurse, and the immediate intervention was to move the resident to another room. The IDT agreed with the room change. The nursing progress notes dated 12/31/24 at 8:30 A.M. documented Resident #6 was found with bruising and skin tears to the face, blood on the face and bathroom floor, feces smeared on the body, and one gripper sock on foot with urine on the floor. The resident stated, I probably hit my head. Vital signs were stable. The nursing notes dated 01/02/25 documented an IDT meeting was held to address the bruising and skin tears. The injury was consistent with contact with the bathroom door, and a night light was ordered for the resident’s room. The facility was unable to provide any investigations into the physical aggression incident on 12/21/24 and any investigation into the injuries of unknown origin Resident #6 sustained. An interview conducted on 08/07/25 at 11:15 A.M. with the Administrator confirmed although injuries and an incident were documented, no formal investigation was initiated to determine the cause or to identify responsible parties. There was no evidence of staff interviews, injury assessments of other residents, or follow-up actions consistent with a proper abuse investigation. The Administrator acknowledged the facility failed to conduct a thorough investigation into the alleged abuse incidents involving Resident #6. Review of the facility policy titled Abuse Prohibition effective 10/14/22 revealed 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 be immediately reported to his/her Administrator. A preliminary, on-site investigation will be initiated within twenty-four (24) hours of any report.

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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 observations, resident and staff interviews, medical record review, and policy and procedure review, the facility failed to provide residents who were dependent on staff for activities of daily living (ADLs) adequate care and services for personal hygiene. This affected four (#8, #15, #134, and #209) of eight residents reviewed for ADLs. The facility census was 209. Findings included: 1. Review of the medical record for the Resident #8 revealed an admission date of 06/02/25. Diagnoses included surgical amputation, chronic obstructive pulmonary disease, alcoholic cirrhosis of liver, peripheral vascular disease, and end stage renal disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had intact cognition and was dependent on staff for showering/bathing, upper body dressing, and personal hygiene. Review of Resident #8's progress notes, shower/bathing sheets, and task information charting sheet for grooming from 07/01/25 to 08/05/25 revealed it did not indicate if staff offered to trim or shave Resident #8's facial hair and/or refused to be shaven. Observation and interview on 08/04/25 at 2:25 P.M. revealed Resident #8 was unshaved, his mustache was long covering his top and bottom lips, and his beard was growing down his neck. The hairs appeared to be at least one inch long. His hair was uncombed. He denied anyone asking if he would like his mustache and beard trimmed or completely shaved off. Resident #8 confirmed he would like his beard and mustache shaved. When asked, if he would like his mustache and beard trimmed or shaved, he replied, “yes. ” The nurse on duty was notified by State Survey Agency. Interview on 08/04/25 at 3:00 P.M. with the Unit Manager (UM) #120 confirmed the certified nursing aides (CNAs) should be asking the residents if they would like their facial hair shaved when ADL care was performed. UM #120 confirmed Resident #8's beard and mustache needed to be groomed. Observations on 08/06/25 at 1:00 P.M. and 08/07/25 at 9:00 A.M. revealed Resident #8 had not been shaved. 2. Review of the medical record for Resident #134 revealed an admission date of 11/23/22. Diagnoses included multiple sclerosis, contracture right hand, and gastrostomy status. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #134 had intact cognition was dependent on staff for showering/bathing, upper body dressing, and personal hygiene. Review of Resident #134’s care plan dated 02/12/25 revealed Resident #134 had a functional ability deficit and required assistance with self-care and mobility related to multiple sclerosis. A goal listed was to improve or maintain current level of function in personal hygiene. An intervention listed was to keep her fingernails trimmed and clean. Observations of Resident #134’s nails on 08/04/25 at 11:12 A.M. and 08/07/25 at 3:48 P.M. revealed her right hand was contracted. Her long fingernails were resting against the palm of her contracted right hand. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #134 on 08/04/25 at 11:12 A.M. revealed she had asked nursing to cut her fingernails frequently. She stated after she would ask to have her nails trimmed, nursing would state they would be back to perform the task, but then would not perform nail care. Interview with Certified Nurse Aide (CNA) #735 on 08/07/25 at 3:57 P.M. revealed Resident #134 did not refuse grooming or care. Interview with CNA #145 on 08/07/25 at 3:58 P.M. revealed Resident #134 did not refuse grooming or care. Interview with CNA #825 on 08/07/25 at 4:00 P.M. confirmed Resident #134’s nails were long and untrimmed. Review of the facility policy titled “Routine Resident Care” dated 03/12/25 revealed daily personal hygiene minimally includes assisting residents with their nail care. 3. Medical record review revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included dementia, psychotic disturbance, mood disturbance, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had impaired cognitive function or impaired thought processes. Resident #15 was dependent on staff for personal hygiene. Review of Resident #15's plan of care, dated 06/02/25, revealed Resident #15 had an ADL functional deficit, and required substantial to maximal assistance with all self-care. Interventions included assistance with upper body dressing, and personal hygiene. Review of Resident #15's nursing notes and behavior monitoring sheets from 07/29/25 to 08/11/25 revealed no documentation Resident #15 was resistive to care. Observations on 08/04/25 at 10:20 A.M. and 12:10 A.M. revealed Resident #15 was in bed propped on his right side and appeared unshaven with a long beard. An interview with Registered Nurse (RN) #130 on 08/04/25 at 2:46 P.M. revealed the men get shaved as needed, if the resident allows staff to shave them. When the certified nursing aides get the resident up and dressed, they should be offering to shave the resident and then the resident can refuse or accept. An interview with RN #130 on 08/04/25 at 2:50 P.M. confirmed Resident #15 had several days growth beard. RN#130 asked Resident #15 if he wanted shaved and Resident #15’s sister said he needs to be shaved. RN #130 asked the sister of Resident #15 if he needed shaved daily and Resident #15’s sister said yes. 4. Record review for Resident #209 revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes mellitus, contracture of the left hand and left elbow, and hemiplegia and hemiparalysis affecting the left non-dominant side. (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 the quarterly Minimum Data Set (MDS) assessment, dated 06/25/25, revealed Resident #209 had moderately impaired cognition and a functional limitation in range of motion to one upper extremity. Resident #209 was dependent on staff for assistance with personal hygiene. Review of the care plan, revised 04/16/25, revealed Resident #209 had a functional ability deficit and required assistance with self care/mobility. Interventions included keep fingernails clean and trimmed. Observations on 08/04/25 at 10:40 A.M. and 2:05 P.M. and 08/0525 at 8:10 A.M., 10:15 A.M., and 1:40 P.M. revealed Resident #209 was lying in bed and the resident's left hand was contracted and the fingernails on the left hand were long and dirty. Observation and interview on 08/05/25 at 4:00 P.M. with Certified Nursing Assistant (CNA) #125 confirmed Resident #209 had a contracture of the left hand and the fingernails on the resident's left hand were long and dirty and in need of being cleaned and trimmed. CNA #125 obtained a damp washcloth and gently cleansed inside the resident's left hand. Upon removing the white washcloth from the resident's hand, brown debris was present. CNA #125 confirmed the residents hand had a yeast-like odor to it which should not be present. Observation on 08/06/25 at 10:02 A.M. revealed Resident #209 was lying in bed. The resident's left hand was contracted and the fingernails to the left hand continued to be long and dirty. Review of the facility policy titled Routine Resident Care effective 03/12/25 revealed daily personal hygiene minimally included assisting or encouraging residents with washing their face and hands, shaving, nail care, and brushing their teeth and/or providing denture care. This represents noncompliance investigated under Complaint Number OH00167220 (1260023).

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The Laurels of Walden Park	5700 Karl Road Columbus, OH 43229

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, interviews with staff at orthopedic medical office, review of National Pressure Injury Advisory Panel (NPIAP) guidance, and facility policy review, the facility failed to implement interventions to prevent the development of pressure ulcers when wearing a splint device and failed to timely identify the resident's pressure ulcers until it reached an advanced stage. Actual harm occurred on 07/30/25 when Resident #37 developed two avoidable unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcers to the underside of the index finger and to the left side of the palm hand when the facility did not remove Resident #37's splint device by the orthopedic clinic's instructions. This affected one (Resident #37) of two residents reviewed for pressure ulcers. The facility census was 209. Findings include: Review of the medical record for Resident #37 revealed an admission date of 08/26/25 with diagnoses including rhabdomyolysis, Alzheimer's disease, generalized muscle weakness, restlessness and agitation, anxiety disorder, and primary generalized osteoarthritis. Review of the care plan dated 08/26/24 revealed there was a skin prevention plan for Resident #37. Interventions included conducting weekly head-to-toe skin assessments; document and report abnormal findings to the physician; and follow facility policies/protocols for the prevention/treatment of impaired skin integrity; The care plan was not updated to reflect Resident #37 was wearing a splint device beginning 05/15/25 and no interventions were added to the care plan to reduce the risk of pressure ulcers with the use of splint device. Review of the after-visit summary (AVS) from Medical Center Orthopedic Clinic #500 revealed Resident #37 was seen on 05/15/25 for left wrist pain. The clinic was unable to obtain a meaningful history from the resident largely due to him being nonverbal and unable to recall any details of his condition. Similarly, his aide accompanying him was also unable to provide a history as to how long the condition had been present. During Resident #37's physical exam, his left wrist had persistent flexion, was unable to passively extend past neutral, sat in full flexion, was very tight and spastic in fingers, his wrist was held in full pronation, his elbow was largely unaffected, and he moved this and his shoulder spontaneously. Overall, he was unable to cooperate with the exam. The results of an x-ray for his left wrist showed some concerns for scapholunate (SL) diastasis, which is a widening (or separation) of the space between the scaphoid and lunate bones in the wrist. The physician's assessment and plan for Resident #37's left spastic hemiplegia stated he did not suspect the deformity was caused by an injury or SL ligament tear. The resident had spastic hemiplegia on the left with unclear etiology. The orthopedic physician stated this was likely due to either a stroke or advancing Alzheimer's disease. The orthopedic physician stated he would fit the resident with a wrist splint to keep him closer to neutral for both comfort and hygiene with no plans for surgical intervention. There were no physician orders on the After Visit Summary. Review of the physician orders dated 05/15/25 revealed an order to remove splint to left wrist and assess skin for any irritation, skin breakdown, swelling, or abnormalities, and report to the medical doctor (MD)/certified nurse practitioner (CNP) if any abnormalities were noted, every shift for prevention. Review of the Braden Scale for Predicting Pressure Sores dated 06/11/25, revealed Resident #37 was at low risk for developing pressure sores with a score of 16. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 was cognitively impaired. Resident #37 was at risk for developing pressure ulcers with a pressure-reducing device for bed and had the application of nonsurgical dressings and ointments. Review of a nursing progress note on 07/30/25 at 6:38 A.M. revealed Resident #37 was given a bed bath this shift, left hand skin under splint was assessed, mild edema was noted on the thumb, index, and middle finger, no new skin issues were noted, and the plan of care continued. A nursing progress note dated 07/30/25 at 3:45 P.M. revealed upon assessment of removal of the resident's splint to left hand, nurse noticed guest had dark skin/scab-like tissue to lateral left thumb and lateral pinky finger. No swelling to wrist or hands, slight amount of swelling to middle finger noted. Betadine was applied to site and wrapped with Kerlix with immediate intervention to discontinue splint order. Wound nurse in building assessed site. Review of the skin and wound evaluation dated 07/30/25 revealed Resident #37 developed an unstageable pressure ulcer to the left plantar - second digit (index finger) proximal, in-house acquired on 07/30/25. The initial measurements were 8.4 centimeters (cm) area, 6. 0 cm in length, 1.9 cm width, not applicable (N/A) for depth, and 100% of the wound filled with eschar (blood and serous fluid) exudate. Additionally, a second skin and wound assessment dated [DATE] revealed

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, staff interviews and review of facility policy, the facility failed to provide residents who had contractures their splint devices as physician ordered. This affected two (Residents #144 and 209) of four residents reviewed for range of motion. The facility identified 19 residents with contractures. The facility census was 209. Findings include: 1. Review of the medical record for Resident #144 revealed an admission date of 03/27/17 . Diagnoses included paralytic syndrome, polyneuropathy, and contracture right hand and wrist 10/01/18. Review of the physician orders dated 11/12/22 revealed Resident #144 was to have a right palm protector applied between 7:00 A.M. and 7:00 P.M. for up to eight hours daily. Review of Resident #144’s care plan dated 10/20/23 and last updated 08/07/25 revealed Resident #144 had a functional ability deficit and required assistance with self-care related to his contracture of his right hand and wrist. A goal was to improve of maintain current level of function in activities of daily living. A listed intervention was to apply right palm protector between 7:00 A.M. and 7:00 P.M. as tolerated for up to eight hours a day. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #144 had moderately impaired cognition and required substantial maximum assistance with upper body dressing and personal hygiene. Review of Resident #144’s comprehensive nursing quarterly assessment dated [DATE] revealed Resident #144 had a decreased range of motion. Observations on 08/04/25 at 12:09 P.M. and 5:15 P.M., 08/05/25 at 7:23 A.M, 10:33 A.M, and 2:29 P.M., and on 08/06/25 at 9:06 A.M. revealed Resident #144 was not wearing his palm protector. An interview with Licensed Practical Nurse (LPN) #630 on 08/06/25 at 9:55 A.M. confirmed Resident #144 was not wearing his palm protector as ordered. LPN #630 stated the restorative aide, Certified Nursing Aide (CNA) #825 was responsible for applying the palm protector for Resident #144. An interview with CNA #825 on 08/06/25 at 10:25 A.M. revealed she did not ever apply the palm protector to Resident #144’s hand. CNA #825 indicated that perhaps the other restorative aide, CNA #885, applied the palm protector to Resident #144. An interview with CNA #885 on 08/06/25 at 10:57 A.M. revealed she did not apply the palm protector to Resident #144 and that the direct daily care CNAs on Resident #144’s hall were responsible for applying the palm protector. 2. Record review for Resident #209 revealed the resident was admitted to the facility on [DATE]. Diagnoses included contracture of the left hand and left elbow, and hemiplegia and hemiparalysis affecting the left non-dominant side. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the active physician's order, dated 08/22/23, revealed to apply left c-roll splint for six hours between 7:00 A.M. and 3:30 P.M. Check skin upon removal. Review of the care plan, revised 04/16/25, revealed Resident #209 had a functional ability deficit and required assistance with self care/mobility. Apply left c-roll splint for six hours between 7:00 A.M. and 3:30 P. M. as tolerated. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/25/25, revealed Resident #209 had moderately impaired cognition and a functional limitation in range of motion to one upper extremity. Observations on 08/04/25 at 10:40 A.M. and 2:05 P.M. revealed Resident #209 was lying in bed and the resident's left hand and elbow were contracted with no splints or other devices in place. Subsequent observations on 08/05/25 at 8:10 A.M., 10:15 A.M., and 1:40 P.M. revealed Resident #209 was lying in bed and the resident's left hand and elbow were contracted with no splints or other devices in place. Observation and interview on 08/05/25 at 4:00 P.M. with Certified Nursing Assistant (CNA) #125 confirmed Resident #209 had a contracture of the left hand and used to have a splint but did not anymore and had not had one in place on the day of the observation. Observation on 08/06/25 at 10:02 A.M. revealed Resident #209 was lying in bed and the resident's left hand and elbow were contracted with no splints or other devices in place. Review of the facility policy titled Brace and Splint Program effective 05/01/24 revealed properly used, splints and braces can enhance mobility, correct alignment, and protect a specific extremity while maintaining skin integrity and circulation.

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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** Based on observation, record review, staff interviews, and facility policy review, the facility failed to complete a thorough fall investigations, failed to ensure residents had adequate footwear to prevent accidents, and failed to appropriately secure the resident's smoking materials. This affected three (Residents #70, #84, and #110) of 12 residents reviewed for accidents. The facility census was 209. Findings include: 1. Review of the medical record for Resident #84 revealed a re-admission date of 12/20/24. Diagnoses included Alzheimer’s disease with late onset, dementia, and osteopenia. Review of the fall risk assessment dated [DATE] revealed Resident #84 was at risk for falls. Review of the plan of care dated 05/17/24 revealed Resident #84 was at risk for falls due to impaired cognition and mobility limitations. Interventions included providing adequate lighting, keeping call light and commonly used items within reach, placing the call light within reach and encouraging the resident to use it for assistance, anticipating and meeting needs as needed, observing for fatigue and unsteadiness and encouraging rest periods as needed, and orienting the resident to surroundings as needed. Review of physician orders for December 2024 identified orders related to fall prevention and management of injuries sustained from the fall. Orders included pain management with acetaminophen as needed for pain relief following the right hip fracture diagnosed post-fall. Mobility orders continued to support the use of a walker and wheelchair for locomotion after the resident returned from the hospital on [DATE]. Review of the nursing notes dated 12/13/24 at 7:30 P.M. revealed Resident #84 was found on the floor in her room with the lights off, complaining of right hip pain and rated it a seven on a pain scale of zero (no pain) to ten (most severe pain). The care plan was immediately adjusted to ensure room lighting remained on. A telehealth note dated 12/14/24 reported an acute right hip fracture diagnosed by X-ray after the fall, with the resident transferred to the hospital for further management. Notes dated 12/16/24 and 12/23/24 documented interdisciplinary team (IDT) meetings addressing the fall and the resident’s return from the hospital, agreeing to continue walker and wheelchair use. Review of the fall investigation dated 12/13/24 revealed the resident had turned off the lights in her room, contributing to the fall. The immediate intervention was to ensure adequate lighting. However, the investigation did not include interviews of staff to determine the root cause of the fall or any additional contributing factors. The care plan was not updated to reflect the use of walker and wheelchair as fall prevention interventions following the resident’s return. The facility failed to comprehensively investigate the fall or modify interventions appropriately. Review of the hospitalization after visit summary (AVS) for Resident #84 revealed an admission date from 12/14/24 to 12/20/24. Resident #84 sustained a fall and was found to have an acute right hip fracture. The x-ray presented a displaced subtrochanteric fracture of the right proximal femur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/08/25, revealed Resident #84 had severely impaired cognition and required maximum assistance for toileting, bathing, chair-to-chair transfers, and toilet transfers; moderate assistance for upper extremity dressing, personal hygiene, rolling left to right, sitting to lying, sit to stand, and walking 10 feet; was dependent on staff for putting on and removing footwear; and used a walker and wheelchair for locomotion. Interview on 08/07/25 at 3:29 P.M. with the Director of Nursing stated she was unsure if the resident was asked what she was attempting to do at the time of the fall. She confirmed the interdisciplinary team met post-return and decided to continue walker and wheelchair use but did not add these to the care plan. She also confirmed the intervention to maintain adequate lighting was not new, having been in place since May 2024, and the lights being off contributed to the fall. Interview on 08/07/25 at 3:46 P.M. with the Unit Manager #140 confirmed the resident used a wheelchair for ambulation requiring staff assistance and the resident slept with the lights off in her room at night. 2. Review of the medical record for Resident #110 revealed an admission date prior to 04/15/25. Diagnoses included dementia, unsteadiness on feet, muscle wasting and atrophy, and agitation managed with olanzapine. Review of the plan of care dated 03/29/25 revealed Resident #110 was at risk for falls due to unsteadiness, muscle weakness, and cognitive impairment. Interventions included encouraging the resident to wear appropriate footwear as needed and maintaining a safe environment with even floors free from spills and clutter. On 04/28/25, a new intervention was implemented to include the resident’s non-skid socks were replaced with a new pair. Review of the nursing notes dated 04/26/25 at 9:30 P.M. revealed Resident #110 was found kneeling in front of the bed with a small skin tear above the right eyebrow and bruising to the right cheekbone and nose bridge after an unwitnessed fall. The resident reported slipping while coming from the bathroom, slipping on the floor with non-slip socks whose grips appeared worn and inadequate. Neurological checks were initiated, pain medication administered, and the socks were replaced with new ones. Review of the fall investigation dated 04/28/25 revealed the cause of the fall was attributed to worn non-slip socks that lacked sufficient grip. Immediate intervention included replacing the socks. The care plan continued to reflect fall prevention strategies but did not specifically address routine inspection or replacement of footwear provided by the facility. Interview on 08/07/25 at 1:42 P.M. with the Director of Nursing stated the root cause of the fall was the resident’s worn non-skid socks. She confirmed the facility provided the socks, which were shared and cleaned between residents, but staff did not routinely check the condition of the socks prior to applying them. She confirmed the only new intervention after the fall was replacing the socks with a new pair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Fall Management last revised on 07/08/2025 revealed the policy aimed to identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls. It outlined an overview where residents were assisted in attaining and maintaining their highest practical level of function by providing adequate supervision, assistive devices, and/or functional programs, with appropriate interventions to minimize fall risk. Residents were evaluated by the interdisciplinary team for their fall risk, and a plan of care was developed and implemented with ongoing review. If a fall occurred, the interdisciplinary team conducted an evaluation to ensure appropriate measures were in place, coordinated by the Director of Nursing or designee. Practice guidelines included evaluating residents for fall risk upon admission, re-admission, quarterly, annually, and with significant condition changes, developing an initial plan of care, evaluating for injury post-fall, completing incident reports, and conducting post-fall evaluations within 24 to 72 hours. The interdisciplinary team reviewed all falls, modified care plans, and conducted monthly reviews, while the Director of Nursing or designee documented changes and reported data to the Quality Assurance and Performance Improvement (QAPI) committee for trending and recommendations. 3. Review of medical record for Resident #70 revealed an admission date of 11/08/24. Diagnoses included peripheral vascular disease, right and left above knee amputations, and muscle wasting. Review of the care plan dated 10/27/24 revealed Resident #70 wished to use smoking products and was assessed as being unsafe to smoke and needed supervision. The goal was listed to be safe while using smoking products and complying with the smoking policy. An intervention listed was that staff members were to maintain all smoking paraphernalia for all safe and unsafe smokers, including lighters. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #70 was cognitively intact, had rejection of care for one to three days during the assessment period, and utilized tobacco. Resident #70 required substantial to maximum assistance from staff for personal hygiene and partial to moderate assistance with oral hygiene. Review of Resident #70’s smoking assessment dated [DATE] revealed Resident #70 required supervision during smoke break related to his hands having contractures and weakness. Resident #70 was not safe to light smoking materials and did not utilize not oxygen. Resident #70 was not a safe smoker. Review of Resident #70’s physician orders dated 06/24/25 revealed Resident #70 had an order for oxygen at six liters to maintain an oxygen level above 88 percent (%) every shift for shortness of breath as needed. Observations of Resident #70 on 08/04/25 at 10:13 A.M., 12:26 P.M., and 2:50 P.M. revealed Resident #70 had two lighters with liquid visible in them at his bedside within reach on his bedside table. Interview with Nursing Administration #130 on 08/04/25 at 2:53 P.M. confirmed the presence of two lighters within reach of Resident #70 at his bedside. Interview with Activity Aide #211 on 08/05/25 at 4:25 P.M. and with Activity Aide #191 on 08/11/25 at 8:24 A.M. revealed even safe smokers were unable to keep lighters or other smoking paraphernalia on their person. All smoking materials were to be locked up in a smoking lock box. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled “Smoking Policy” dated 06/17/25 revealed staff members will maintain all smoking paraphernalia for all safe and safe smokers, including lighters and lighter fluid. This deficiency represents non-compliance investigated under Complaint Number OH00167527 (1260015).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, policy review, and review of hospital records, the facility failed to provide adequate respiratory care for Resident #47 who had localized fly larvae infestation to her tracheostomy and stoma and required hospitalization. This affected one (#47) of five residents reviewed for respiratory care. The facility identified 36 residents residing on the tracheostomy unit. The facility census was 209. Findings included: Review of Resident #47's medical record revealed an admission date of 10/23/24. Diagnoses included acute and chronic respiratory failure, hemiplegia and hemiparesis, tracheostomy and ventilator dependent. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had severely impaired cognition. Resident #47 was also totally dependent on staff for all care including tracheostomy care. Review of the active physician orders revealed Resident #47 was to receive tracheostomy care every 12 hours which included changing of the disposable inner cannula and to check the skin under the tracheostomy ties on each shift as well. Review of the Treatment Administration Record (TAR) from 04/01/25 to 07/31/25 revealed all tracheostomy care had been completed and signed off by various Respiratory Therapists. Review of the nursing note from 06/30/25 at 5:13 A.M. from Licensed Practical Nurse (LPN) #680 revealed multiple fly larvae (maggots) in and on the tracheostomy site of Resident #47. An order was received to send the resident to the emergency room for further evaluation. Review of the hospital notes dated 06/30/25 revealed three larvae were identified upon arrival to the emergency room. The infestation was removed locally in the emergency room with all larvae being successfully removed. Infectious Diseases was consulted with no recommendations except local removal. Ventilator dependent pneumonia was also summarily ruled out. Wound care was consulted with no recommendations except local removal. Notes state a debridement of the tracheostomy stoma was not necessary. Resident #47 returned to the facility on [DATE]. Observation on 08/05/25 at 10:10 A.M. revealed multiple house flies and fruit flies were flying around the tracheostomy unit. The flies were also landing on multiple surfaces during this observation. Observation of Resident #47 on 08/06/25 at 9:45 A.M. revealed the resident's room was located next to an exit door that opens up to the outside. No observations were made of staff or residents utilizing this door to the outside as it had a sign posted to be used for emergency purposes only. Subsequent observations on 08/06/25 at 12:25 P.M., 08/07/25 at 2:10 P.M., and 08/11/25 at 9:55 A.M. revealed multiple house flies and fruit flies were flying around the tracheostomy unit. The flies were also landing on multiple surfaces during these observations. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Respiratory Therapist #945 on 08/06/25 at 2:45 P.M. verified the tracheostomy and stoma of Resident #47 had been infested with fly larvae and the resident had been sent to the hospital due to the findings on 06/30/25. He stated tracheostomy care was scheduled once per shift, and the eggs may hatch into their larval form in approximately 12 hours. He also verified that due to the findings on that day, the facility had installed florescent fly traps at the ends of each hall and prohibited entry or exiting from the outside doors located at the end of each hall. Prior to 06/30/25, staff frequently used the exit doors on the tracheostomy for various reasons. Attempts to interview Licensed Practical Nurse #680 and Respiratory Therapist #955, who worked on 06/30/25, during the survey were unsuccessful. Review of the facility's undated policy titled Tracheostomy Suctioning revealed there was no relevant information on the care required for fly larvae infestation. This deficiency represents non-compliance investigated under Complaint Number OH00167441 (1260024) and Complaint Number OH00167149 (1260022).

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

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to consistently evaluate the effectiveness of regularly scheduled opioid pain medication in accordance with the resident's comprehensive care plan. This affected one (#159) of five residents reviewed for unnecessary medications. The facility census was 209. Findings include:Review of Resident #159's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included fibromyalgia (long-term condition that involves widespread body pain) and polyarthritis (a form of arthritis affecting five or more joints simultaneously, causing pain, swelling, warmth, and stiffness). Review of the physician order summary dated 03/04/25 revealed Resident #159 had an order for Tramadol (an opioid and treats moderate to severe pain) 50 milligrams (mg) give one tablet by mouth two times a day for polyarthritis. Review of the care plan dated 06/29/25 revealed Resident #159 was at risk for chronic pain and the interventions included evaluate the effectiveness of pain medication as given and review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition as needed. Review of the medication administration record (MAR) from 07/01/25 to 08/11/25 for Resident #159 revealed an order for Tramadol HCL oral tablet 50 mg, give one tablet by mouth two times a day for polyarthritis, scheduled at 8:00 A.M. and 8:00 P.M. There was no pain scale and effectiveness of the medication in association with the administration of Tramadol in the MAR, treatment administration record (TAR), and progress notes. Review of Resident #159's Pain Level Summary from 05/11/25 to 08/11/25 revealed there were no records of a pain level during this time. An interview with Registered Nurse (RN) #660 on 08/11/25 at 9:19 A.M. verified there was no pain scale in Resident #159's MAR or medical record. RN #660 stated that most of the residents have a pain scale and verified there was no documentation the staff were monitoring the effectiveness of Tramadol for Resident #159. An interview with Certified Nurse Practitioner (CNP) #51on 08/11/25 at 9:27 A.M. confirmed any resident receiving scheduled Tramadol should be assessed for pain every time it was given and then evaluated for effectiveness of the Tramadol. Review of the facilities Pain Management policy last revised 3/05/25 revealed each resident identified with pain will have a pain management care plan. The care plan will have: a consistent pain scale to measure the pain and frequency of re-evaluation, a desired level of pain reduction or acceptable level of pain, resident-centered functional outcomes (e.g., ability to participate in favorite activity, visiting with family, ambulating to the dining room, sleeping through the night), pain monitoring and who will monitor for the pain, nursing comfort measures to alleviate pain, and potential adverse effects of treatment.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interviews, and review of facility policy, the facility failed to identify post traumatic stress disorder (PTSD) triggers on the care plan for Resident #48 and failed to assess Resident #8 for PTSD upon admission. This affected two (Residents #8 and #48) of five residents reviewed for mood and behavior. The facility census was 209.Findings include: 1. Review of the medical record for Resident #48 revealed an admission date of 06/17/25. Diagnoses included PTSD, anxiety disorder, and depression. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #48 was cognitively intact and did not have behaviors. Review of the social services evaluation dated 06/27/25 revealed Resident #48 had experienced a loss of a significant other and a traumatic event of a motor vehicle accident with mass casualties. Symptoms due to her PTSD included flashbacks, hypervigilance, fear, severe anxiety, loneliness and unwanted thoughts. Triggers included people, thoughts and feelings. Review of the care plan dated 07/04/25 revealed Resident #48 had potential for fluctuations in mood due to PTSD. A goal listed was to have stable or improved mood and no signs of symptoms of anxiety. Interventions included administering medications as ordered, approaching in a calm, quiet manner, assisting in developing an activity program, assisting resident to identify coping skills, encouraging resident to verbalize feelings, and observing and reporting to social worker and/or physician when resident has acute change in mood or behavior or when resident is at risk for harm to self. The care plan did not identify any triggers that may help caregivers to not be re-traumatized. Interview with Social Worker #771 on 08/06/25 at 9:23 A.M. confirmed Resident #48’s care plan did not include identified triggers that may re-traumatize Resident #48. 2. Review of the medical record for Resident #8 revealed an admission date of 06/02/25. Diagnoses included surgical amputation, chronic obstructive pulmonary disease , alcoholic cirrhosis of liver, and end stage renal disease. Review of Resident #8's medical record from 06/02/25 to 08/11/25 revealed no indication Resident #8 was accessed for PTSD. An interview on 08/04/25 at 2:28 P.M. with Resident #8 stated he was sad and very depressed. Resident #8 stated he lost his only child (son) to suicide on Easter, April 2025 and recently had his right leg amputated, becoming a bilateral amputee of both legs losing his independence. He denied being suicidal and asked if he could talk to someone. Interview on 08/12/25 at 9:30 A.M. with Social Service Designee #771 confirmed there was no PTSD assessment completed for Resident #8. She was unaware of him losing a son in April of 2025. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled “Social Service Documentation” dated 08/01/24 revealed the facility is committed to providing culturally competent, trauma informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. If trauma is identified, care plans to address the trauma, including triggers and interventions to mitigate or lessen re-traumatization will be authored.

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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. Based on observation, staff interview, record review, review of Centers for Disease Control and Prevention (CDC) guidance and review of facility policy, the facility failed to ensure staff followed Enhanced Barrier Precautions (EBP) in designated resident rooms. This affected one (Resident #10) of four residents reviewed for EBP. The facility census was 209. Findings included:Review of the medical record for Resident #10 revealed an admission date of 07/15/21. Diagnoses included chronic obstructive pulmonary disease. Review of Resident #10's physician orders for 08/01/25 to 08/11/25 revealed an active order for Resident #10 to be on EBP related to chronic wound. Observation on 08/05/25 at 2:40 P.M. revealed Certified Nursing Assistant (CNA) #115 assisting Resident #10 at the bedside with gloves on. He went into the resident's bathroom and exited out of the room with gloved hands. CNA #115 was not wearing a gown during provision of care. Interview on 08/05/25 at 2:42 P.M. with CNA #115 confirmed he performed incontinence care for Resident #10 with gloves only. CNA #115 confirmed he did not wear a gown as indicated by the EBP sign outside Resident #10's room. Observation on 08/05/25 at 3:52 P.M. of Resident #10 who resided in bed B revealed outside of her room to the right of her door were two signs for EBP for bed A and Resident #10 bed B. The sign indicated providers and staff must clean their hands, including before entering and when leaving the room, wear gloves and a gown for the following activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use central line, urinary catheter, feeding tube, tracheostomy and wound care (any opening requiring a dressing). Review of the facility policy titled “Enhanced Barrier Precautions (EBP)” dated 03/05/25 revealed the facility is to use EBP in addition to standard precautions for preventing transmission of CDC targeted multidrug-resistant organisms (MDROs). EBP are indicated for residents with chronic wounds. Health care personnel caring for residents on EBP should wear gloves and gowns during high-contact resident care such as dressing, bathing showering, transferring providing hygiene(focused on A.M. and P.M. care) changing linens, changing briefs or assisting with toileting, device care or use, central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: chronic wounds. Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, resident interviews, staff interviews, and review of facility policy, the facility failed to maintain an effective pest control program. This affected eight residents (#47, #57, #70, #90, #116, #134, #179, and #225) and had the potential to affect all residents living in the facility. The facility census was 209. Findings include: 1. Interview with Resident #90 on 08/04/25 at 9:53 A.M. revealed gnats and roaches were present in the facility on a daily basis. Interview and observation with Resident #57 on 08/04/25 at 9:51 A.M. revealed gnats were present in his room on a daily basis. Several gnats were observed flying around the room and landing on the privacy curtain. Interview and observation with Resident #70 on 08/04/25 at 10:13 A.M. revealed gnats were present in his room on a daily basis. He stated he told management about the gnats in his room. Several gnats were observed to be flying around the room and landing on Resident #70’s tray table. Interview with Resident #116 on 08/04/25 at 10:32 A.M. revealed roaches were in her room on a daily basis and she could feel them crawling on her while she was in bed at times. Interview with Resident #134 on 08/04/25 at 11:12 A.M. revealed roaches and gnats were in her room on a daily basis. Interview and observation with Resident #179 on 08/04/25 at 11:23 A.M. revealed roaches were in the room on a daily basis. A roach was observed crawling across his side table. Resident #179 stated he was concerned they would enter into his continuous positive airway pressure machine or tubing. Interview with Resident #225 on 08/04/25 at 11:35 A.M. revealed he killed multiple roaches crawling across his wall on a daily basis. Observation of a roach crawling on the Unit One hallway was confirmed by Registered Nurse #320 on 08/05/25 at 9:12 A.M. Observation and interview on 08/11/25 at 11:08 A.M. with Maintenance Worker #811 confirmed there were ten gnats that had landed on Resident #57’s privacy curtain. Upon shaking the privacy curtain, the gnats were observed to be alive and flying around the room. Interview with Certified Nursing Assistant (CNA) #205 on 08/06/25 at 11:06 A.M. confirmed there were active roaches in the facility. Interview with Housekeeper #591 on 08/11/25 at 10:49 A.M. confirmed she saw live roaches and gnats in resident rooms on a daily basis. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Administrator on 08/11/25 at 2:58 P.M. confirmed the pest infestation was ongoing. Although the facility had an active plan to eradicate the pests and pest control education was provided to staff, the facility had not yet assessed the skin of vulnerable residents as part of their correction plan. The Administrator revealed licensed staff would perform skin assessments of vulnerable residents as a part of this correction plan starting immediately. 2. Observation on 08/05/25 at 10:10 A.M. revealed multiple house flies and fruit flies were flying around the tracheostomy unit. The flies were also landing on multiple surfaces during this observation. Observation of Resident #47 on 08/06/25 at 9:45 A.M. revealed the resident's room was located next to an exit door that opens up to the outside. Subsequent observations on 08/06/25 at 12:25 P.M., 08/07/25 at 2:10 P.M., and 08/11/25 at 9:55 A.M. revealed multiple house flies and fruit flies were flying around the tracheostomy unit. The flies were also landing on multiple surfaces during these observations. Interview with Respiratory Therapist #945 on 08/06/25 at 2:45 P.M. verified the tracheostomy and stoma of Resident #47 had been infested with fly larvae and the resident had been sent to the hospital due to the findings on 06/30/25. Review of an undated facility policy titled “Pest Control Policy” revealed the facility would provide an environment free of pests. This deficiency represents non-compliance investigated under Complaint Number OH00167149 (1260022).