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	10/09/2025

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

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

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

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, open and closed medical record review, interviews and facility policy review, the facility failed to ensure weekly comprehensive wound assessments were completed, ensure skin interventions were in place and ensure wounds were accurately classified. This affected two residents (#117 and #214) of three residents reviewed for wounds. The facility census was 209.Findings Include:1.Review of the closed record for Resident #214 revealed an initial admission date of 07/17/25 with the latest readmission of 08/10/25 with the diagnoses including but not limited to chronic kidney disease, moderate protein calorie malnutrition, bacteremia, chronic bronchitis, acute respiratory failure with hypoxia, metabolic encephalopathy, fatty liver, hypertension, anemia, secondary hyperparathyroidism of renal origin, chronic peripheral venous insufficiency, dysphagia, muscle wasting and atrophy, difficulty in walking, benign neoplasm of colon, dependence on renal dialysis, abdominal aortic aneurysm, gout, benign neoplasm of left kidney, polyneuropathy, chronic pain syndrome, depression, guttate psoriasis, constipation, osteoporosis, hyperlipidemia, anxiety disorder and non-compliance with medication regimen.Review of the resident's nursing comprehensive evaluation dated 07/17/25 revealed the resident was admitted to facility with excoriation to the sacrum, groins, left buttocks and right buttocks possibly related to an allergy to Zosyn. The assessment indicated the resident was incontinent of both bowel and bladder.Review of the nurses note dated 07/18/25 at 4:33 P.M. revealed the resident was seen by the wound nurse for new admission assessment. The resident presented to the facility with an allergic reaction rash to entire body. The resident also presented with dry red patches/flaky tissue due loss of epidermis and crust to entire body and linear scratches and scabs due to resident scratching. The resident also presented with Moisture Associated Skin Damage (MASD) to buttocks secondary to diarrhea. Review of the plan of care dated 07/18/25 revealed the resident had actual impairment to skin integrity related to Moisture Associated Skin Damage (MASD) to buttocks, sacrum, open lesions to right scapula and mid back. Interventions included administer medications as ordered, observe for ineffectiveness and side effects, report abnormal findings to the physician, conduct weekly head to toe skin assessments and report new/abnormal findings to physicians as needed, apply (specify: pressure relieving/reducing mattress, pillows, etc.) to protect the skin while in bed, educate resident/family/caregivers of causative factors and measures to prevent skin injury, encourage good nutrition and hydration in order to promote healthier skin, provide dietary supplements as ordered, instruct resident to avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, keep skin clean and dry, use lotion on dry skin, observe for signs/symptoms of infection of area, observe for side effects of the antibiotics and over-the-counter pain medications, observe location, size and treatment of skin injury, report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to physician, obtain temperature as indicated while on antibiotic, treatment to skin impairment per order and turn and reposition. Review of the resident's Braden scale dated 07/19/25 revealed a score of 18 indicating the resident was at a low risk for skin breakdown.Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident required partial/moderate assistance to sit on the side of the bed. The resident was at risk for skin breakdown and had no skin issues. The facility implemented the interventions pressure reducing device to bed, application of non-surgical dressings and application of dressings to feet. Review of the closed medical record revealed no weekly comprehensive assessment for the MASD until 08/14/25 when the resident was found to have Moisture Associated Skin Damage (MASD) to the sacrum measuring 9.2 centimeters (cm) by 12.0 cm by 0.1 cm and described as being pink and/or red in color with no exudate. The facility implemented to cleanse the areas with soap and water and apply Triad paste. Review of the resident's skin and wound evaluation dated 08/20/25 revealed the MASD to the sacrum measured 6.5 cm by 6.8 cm and described as being pink and/or red in color with light sanguineous/bloody exudate. The facility determined the wound was stable and continued the current treatment.On 09/25/25 at 10:53 A.M., an interview with Licensed Practical Nurse (LPN) #407 who functions as one of the two wound nurses for the facility revealed the resident was admitted to the facility with MASD and also a rash. The LPN revealed she charted on the wound weekly, however failed to document a weekly comprehensive assessment of the wound until 08/14/25. LPN #407 verified the MASD should have been comprehensively assessed weekly.On 09/29/25 at 9:05 A.M., an interview with the Director of Nursing (DON) verified the MASD should have been comprehensively assessed weekly. 2

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, fall investigation review, interviews and facility policy review, the facility failed to provide the care and supervision to prevent an unavoidable fall. This affected one resident (#214) of three residents reviewed for falls. The facility census was 209.Findings Include:Review of the closed record for Resident #214 revealed an initial admission date of 07/17/25 with the latest readmission of 08/10/25 with the diagnoses including but not limited to chronic kidney disease, moderate protein calorie malnutrition, bacteremia, chronic bronchitis, acute respiratory failure with hypoxia, metabolic encephalopathy, fatty liver, hypertension, anemia, secondary hyperparathyroidism of renal origin, chronic peripheral venous insufficiency, dysphagia, muscle wasting and atrophy, difficulty in walking, benign neoplasm of colon, dependence on renal dialysis, abdominal aortic aneurysm, gout, benign neoplasm of left kidney, polyneuropathy, chronic pain syndrome, depression, guttate psoriasis, constipation, osteoporosis, hyperlipidemia, anxiety disorder and non-compliance with medication regimen.Review of the resident's nursing comprehensive evaluation dated 07/17/25 revealed the resident required one assist with transfers and ambulation and the resident had a history of falls and a fear of falling. Review of the plan of care dated 07/18/25 revealed the resident was at risk for injury and falls related to medication effects, opioid use, impaired vision, hearing loss, depression, anxiety, impaired mobility, incontinence of bowel and bladder, unsteady gait and pain. Interventions included administer medications as ordered, anticipate and meet needs as needed, do not leave resident unattended in the bathroom, encourage the resident to wear appropriate footwear as needed, follow facility fall policy, Hoyer lift for transfers, keep the resident's environment as safe as possible, orient to surrounds as needed, provide resident with activities that minimize the potential for falls while providing diversion and distraction, therapy to evaluate and treat as ordered and as needed, put the call light withing reach and encourage him to use it for assistance as needed and staff educated not to leave the resident unattended at the side of his bed and utilize the Hoyer lift for transfers.Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident required partial/moderate assistance to sit on the side of the bed. The assessment indicated the resident had a history of calls prior to admission to the facility. Review of the progress note dated 08/16/25 at 6:00 A.M. revealed the nurse was called to the resident's room due to a fall. The resident was noted on the floor between the bed and his dialysis chair. Two superficial skin tears were observed to his left arm. The resident reported, I slid off the bed as I was waiting on my washcloth. The facility implemented the intervention to not leave the resident sitting on the side of the bed alone. Review of the fall investigation dated 08/16/25 at 6:00 A.M. revealed the nurse was called to the resident's room due to a fall. The resident was noted on the floor between the bed and his dialysis chair, and two superficial skin tears were observed to his left arm. The resident reported, I slid off the bed as I was waiting on my washcloth. Review of the post fall evaluation dated 08/16/25 revealed the resident was sitting on the side of the bed unattended and slipped. The resident was found in between his bed and dialysis chair. The post fall evaluation determined the root cause was the resident was unattended sitting on the side of the bed getting ready for dialysis when he slipped between the bed and dialysis chair. Staff were educated to not leave the resident unattended sitting on the side of the bed. The interdisciplinary team (IDT) also placed the new intervention to make the resident a Hoyer lift with transfers. On 09/25/25 at 12:48 P.M., an interview with the Director of Nursing (DON) verified the resident was left sitting on the side of the his bed alone while the Certified Nursing Assistant (CNA) left the room leaving the resident unsupervised. The DON verified the resident fell from his bed when the CNA left the room leaving the resident unattended.Review of the facility policy titled, Fall Management, last revised on 07/08/25 revealed the facility will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls.This deficiency represents non-compliance investigated under Complaint Number 2604004 and a recite to the annual survey conducted on 08/13/25.