

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Laurels of MT Vernon The		STREET ADDRESS, CITY, STATE, ZIP CODE 13 Avalon Road Mount Vernon, OH 43050	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, review of a facility investigation, review of the facility abuse policy, and interview, the facility failed to protect from abuse Resident #87, who exhibited severe cognitive impairment (with a Brief Interview for Mental Status score of two) and had the diagnoses of unspecified dementia and cognitive communication deficit. This resulted in verbal and physical abuse occurring on 04/12/24 at 7:28 P. M. by Licensed Practical Nurse (LPN) #655 when Resident #87 was yelled at and forcibly placed back into the wheelchair. This affected one resident (#87) of six residents reviewed for dementia care. The facility census was 83.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #87 revealed an admitted [DATE] with the diagnoses including unspecified dementia, cognitive communication deficit, depression, anxiety, and difficulty in walking. Resident #87 required assistance from staff for activities of daily living (ADLs) tasks and used a wheelchair for mobility. Resident #87 was discharged to home on 04/14/24.</p> <p>Review of Resident #87's comprehensive care plan dated 04/04/24 revealed Resident #87 was incontinent of both bowel and bladder and required assistance from staff for incontinence care. Resident #87 was at risk for decline in cognition and had impaired cognitive function related to dementia, short attention span, and inability to follow directions. Resident #87 had the potential for fluctuations in mood related to dementia.</p> <p>Review of the progress notes for Resident #87 dated 04/12/24 at 8:05 P.M. authored by Assisted Director of Nursing (ADON) #412 revealed a head-to-toe skin assessment was completed with negative results noted.</p> <p>Review of the progress notes for Resident #87 dated 04/11/24 at 10:30 P.M. to 04/12/24 at 5:15 A.M. revealed Resident #87 was exhibiting aggressive behaviors towards staff and self-harming behaviors. Resident #87 was transferred to the hospital emergency room for evaluation and treatment. Resident #87 returned to the facility with the diagnosis of urinary tract infection and order for antibiotic use.</p> <p>(continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician orders for Resident #87 revealed an order dated 04/12/24 for the antibiotic Doxycycline 100 mg by mouth two times per day for seven days to treat urinary tract infection.</p> <p>Review of the facility's completed investigation initiated on 04/12/24 revealed the following statements as part of the facility investigation included but were not limited to:</p> <p>A written statement completed by ADON #412 dated 04/12/24 at 7:28 P.M. revealed, LPN #655 was witnessed by (State tested Nursing Assistant) STNAs #486 and #499 yelling at Resident #87 using profanities and pushing her into her wheelchair very aggressively.</p> <p>A verbal interview conducted by ADON #412 dated 04/12/24 at 8:20 P.M. via telephone conversation with STNA #486 revealed, I witnessed LPN #655 yell and cuss at Resident #87 in her face and aggressively shoved her down into her wheelchair. LPN #655 used profanity and was screaming at Resident #87 we are not doing this tonight.</p> <p>A verbal interview conducted by ADON #412 dated 04/12/24 at 8:35 P.M. via telephone conversation with STNA #499 revealed, I witnessed LPN #655 screaming at Resident #87 after she had hit LPN #655. LPN #655 yelled profanities saying, Who do you think you are? Then said, I'm sending her out, I'm dealing with this tonight.</p> <p>A verbal interview conducted by ADON #412 dated 04/13/24 via telephone conversation with STNA #480 revealed, states she didn't witness anything that would be mistreatment of Resident #87. States that STNA #486 and #499 took over trying to calm Resident #87 and the only thing she witnessed was everyone trying to calm Resident #87 down from the behaviors she was having.</p> <p>A verbal interview conducted by ADON #412 dated 04/13/24 at 10:00 A.M. via telephone conversation with STNA #504 revealed, I witnessed LPN #655 being mean, using foul language, and being not nice to Resident #87. The physical interactions of Resident #87 being shoved down into her wheelchair and the way she was talking to her was very inappropriate.</p> <p>Review of the in-depth analysis of how the deficiency occurred dated 04/12/24 authored by the Administrator revealed, Resident #87 was confused and trying to get out her wheelchair repeatedly and the nurse yelled at the resident.</p> <p>Interview on 05/06/24 at 3:17 P.M. with ADON #412 revealed on 04/12/24 at 7:30 P.M. she was notified by STNAs #486 and #499 reporting the yelling, cussing and physical force used by LPN #655 towards Resident #87. ADON #412 revealed they went into the facility then and spoke with LPN #655 concerning the situation, notified the Administrator and then suspended LPN #655 pending investigation. ADON then assessed Resident #87 for any injuries that may have occurred during the altercation. I did not observe any injuries. Resident #87 was known for having behaviors since her admission to the facility and she was also being treated for a urinary tract infection. LPN #655 was suspended and then was terminated a couple days later.</p> <p>Interview on 05/06/24 at 4:05 P.M. with Regional Nurse Consultant (RNC) #650 confirmed LPN #655 did yell at and forcibly place Resident #87 into the wheelchair. RNC #650 revealed the ADON conducted the investigation due to the Director of Nursing being on vacation. LPN #655 was reported to the Ohio Board of Nursing and was terminated from employment at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/07/24 at 10:31 A.M. with SS #574 revealed they attempted to follow up with Resident #87 the next day. SS #574 couldn't have a conversation with her due to her impaired cognition. Resident #87 appeared that she did not remember the incident and she did not appear in any type of distress.</p> <p>Review of the facility's policy titled, Abuse Prohibition Policy dated 10/04/22 revealed, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property.</p> <p>The abuse was reported and subsequently corrected on 04/14/24 when the facility implemented the following corrective actions:</p> <p>On 04/12/24 at 7:30 P.M. Resident #87 was removed from the activity lounge by STNAs #486 and #499.</p> <p>On 04/12/24 at 7:40 P.M. LPN #655 was suspended from work pending investigation of the incident by the ADON #412.</p> <p>On 04/12/24 at 7:50 P.M. ADON #412 conducted a head-to-toe skin assessment for Resident #87 with negative results documented.</p> <p>On 04/12/24 at 8:05 P.M. all staff abuse prohibition policy review and reeducation was initiated by ADON #412 via in -person and verbal education and was completed on 04/13/24.</p> <p>On 04/14/24 LPN #655 was terminated from employment at the facility by the Administrator.</p> <p>On 04/16/24 a weekly audit was initiated by SS #574 for five random residents to be interviewed to ensure that they feel safe, for the next four weeks with the results to be reviewed by the facility's interdisciplinary team (IDT) and the next scheduled quality assurance and performance improvement (QAPI) meeting.</p> <p>On 04/23/24 LPN #655 was reported to the Ohio Board of Nursing by the Administrator.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153282.</p>		