STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365404	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of MT Vernon The	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 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 record review, review of the abuse policy and Quality Assurance Performance Improvement (QAPI) Committee policy, and interview, the facility failed to implement policies and procedures to communicate and coordinate with the QAPI program regarding situations of abuse, neglect, and misappropriation of resident property, and exploitation. This affected four residents (#1, #2, #14, and #24) and had the potential to affect all 86 residents residing in the facility. The facility census was 86.Findings include:1. Review of the medical record for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses including anxiety disorder, major depressive disorder, and Alzheimer's disease. Review of an incident and accident investigation form revealed on 06/06/25 at 5:00 P.M. Resident #1 was holding onto Resident #2 in the memory care unit before the supper meal. When staff asked Resident #1 to let go of Resident #2, Resident #1 shoved Resident #2 as she let go. Resident #2 fell backwards. The investigation form revealed staff witnessed the incident. Resident #1 was put on 15-minute checks and Resident #2 was sent to the hospital. The form indicated resident files were not reviewed, no other documentation was reviewed, and no additional interviews were conducted. A brief description of conclusion revealed Resident #1 and Resident #2 were separated immediately. Resident #2 was sent to the hospital for evaluation and Resident #1 was placed on 15-minute checks. Resident #1 and Resident #2 did not remember the incident. A review of others that may be at risk was marked as yes but no information was provided indicating what review was completed. The plan to avoid this situation in the future was to redirect away from each other during meals and the nursing staff and Director of Nursing would monitor the corrective action. The facility abuse prohibition policy revised 09/09/22 revealed allegations of resident abuse, exploitation, neglect, misappropriation of property, adverse events, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative. The subject of abuse should be routinely and openly discussed. Guests/residents would be educated concerning the commitment of the facility to deal quickly and effectively with abuse or suspected abuse incidents on admission and at least annually. The Administrator, Director of Nursing or designee would compile a final summary of all investigations and report the findings at the facility QAPI committee meeting(s).The QAPI Committee policy revised 03/05/25 revealed the QAPI committee oversees and identifies all efforts that improved the quality of care in the facility by monitoring performance measures, developing and implementing appropriate performance improvement plans to correct quality concerns, and evaluating the effectiveness of the performance improvement plans. The following reports, logs and similar documents were created by or at the direction of, and for use by, the QAPI committee. These reports logs and similar documents were used to determine improvement priorities based on facility-identified concerns. These reports, logs and similar documents were: incident/accident summary reports, incident/accident logs and other related data, and all investigations including adverse events and medical errors. The QAPI committee shall collect and analyze data about the facility's performance and present findings to the committee. An interview on 08/06/25 at 5:14 P.M. Licensed Nursing Home Administrator (LNHA) revealed a log of incidents were verbally discussed during QAPI; however, there was no documentation of what was discussed or what the findings of the discussion were as they pertained to the incident involving Resident #1 and Resident #2. 2. Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, psychosis, major depressive disorder, and adjustment disorder with disturbance of conduct. Review of an incident and accident investigation form dated 03/25/25 at 11:40 A.M. revealed Resident #24 entered Resident #14's room and was rummaging through Resident #14's things. Resident #14 asked Resident #24 to leave his room. Resident #24 became agitated and hit Resident #14 in the abdomen. Resident #14 then hit Resident #24 in the right upper arm. Staff entered the room and separated the residents as Resident #14 was hitting Resident #24. Staff became aware of the incident when Resident #14 was yelling for Resident #24 to get out of his room. Resident #14 was questioned about the incident. Certified Nursing Assistant (CNA) #100 was interviewed about the incident. Resident #14 was placed on 15-minute checks and Resident #24 was placed on one-on-one observation. No injuries were noted other than redness to Resident #24's right arm and redness to Resident #14's abdomen. A review of others that may be at risk was marked as yes but no information was provided indicating what review was completed. The plan to avoid this situation in the future was to place a stop sign on Resident #14's door because it was

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 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 review of medical records, review of facility investigations, review of the abuse policy, and interview, the facility failed to thoroughly investigate allegations of abuse for Residents #1, #2, #14, and #24. This affected four (Residents #1, #2, #14, and #24) out of six residents reviewed for abuse investigations. The facility census was 86.Findings include:1. Review of the medical record revealed Resident #1 was admitted on [DATE] with diagnoses that included but not limited to anxiety disorder, major depressive disorder, and Alzheimer's disease. A nurse's note dated 06/06/25 at 6:07 P.M. revealed Resident #1 had a hold of another resident's (Resident #2) arm. A certified nurse assistant (CNA) asked Resident #1 multiple times to let go of Resident #2's arm. When Resident #1 decided to let go of Resident #2, Resident #1 pushed Resident #2 on the floor. Resident #2 fell and hit her head on the floor.Review of self-reported incident (SRI) #261328 dated 06/06/25 revealed Resident #1 was observed holding Resident #2 in the activity room of the memory care unit. When staff asked Resident #1 to let go of Resident #2, Resident #1 shoved Resident #2 as she let go which resulted in Resident #2 falling backwards. Resident #2 had a laceration to the back of the head and was sent to the hospital for evaluation. Resident #1 was placed on 15-minute checks. Review of the incident and accident investigation form revealed on 06/06/25 at 5:00 P.M. Resident #1 was holding onto Resident #2 in the memory care unit before the supper meal. When staff asked Resident #1 to let go of Resident #2, Resident #1 shoved Resident #2 as she let go. Resident #2 fell backwards. The investigation form revealed staff witnessed the incident. Resident #1 was put on 15-minute checks and Resident #2 was sent to the hospital. The form indicated resident files were not reviewed, no other documentation was reviewed, and no additional interviews were conducted. A brief description of conclusion revealed Resident #1 and Resident #2 were separated immediately. Resident #2 was sent to the hospital for evaluation and Resident #1 was placed on 15-minute checks. Resident #1 and Resident #2 did not remember the incident. A review of others that may be at risk was marked as yes but no information was provided indicating what review was completed. The plan to avoid this situation in the future was to redirect away from each other during meals and the nursing staff and Director of Nursing would monitor the corrective action. Review of the medical record revealed the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had severe cognitive impairment. The MDS also revealed Resident #1 had verbal behaviors directed at others for one to three days during the assessment period.An interview on 08/06/25 at 5:14 P.M. Licensed Nursing Home Administrator (LNHA) verified the investigation did not include witness statements and the information on the incident and accident investigation form was obtained from the nurse's note dated 06/06/25 at 6:07 P.M. LNHA verified a complete and thorough investigation was not completed. Review of the Abuse Prohibition Policy revised 09/09/22 revealed it is the responsibility of all staff to provide a safe environment for the residents. Allegations of resident abuse, exploitation, neglect, misappropriation of property, adverse events, or mistreatment shall be thoroughly investigated and documented by the LNHA. The investigation may consist of (as appropriate) a review of the completed incident report, an interview with the person reporting the incident, and interview with the resident, if possible, an interview with staff members who had contact with the resident during the period/shift of the alleged incident, and a review of all circumstances surround the incident. 2. Review of the medical record revealed Resident #24 was admitted on [DATE] with diagnoses that included but limited to Alzheimer's disease, psychosis, major depressive disorder, and adjustment disorder with disturbance of conduct.A nurse's note dated 03/25/25 at 12:34 P.M. revealed Resident #24 went into another resident's (Resident #14) room. Resident #14 asked Resident #24 three times to leave Resident #14's room. Resident #24 started yelling at Resident #14. Resident #24 then slapped Resident #14 on the abdomen. Resident #14 then slapped Resident #24 on the right arm. A CNA removed Resident #24 from Resident #14's room. The nurse did a skin check and noted Resident #24 had redness to the right upper arm. Resident #24 was placed on one-on-one supervision. Review of SRI #258622 dated 03/25/25 revealed Resident #24 wandered into Resident #14's room. Resident #14 tried to get Resident #24 to leave, and Resident #24 struck Resident #14 in the stomach and Resident #14 struck Resident #24 on the arm. Residents #14 and #24 were immediately separated and no injuries occurred. Resident #14 stated they were not afraid of Resident #24. Resident #24 could not describe what happened. Resident #24 was placed on one-on-one observation and was transferred to a behavior facility for evaluation and treatment on 03/26/25. Resident #14 was placed on 15-minute checks. Review of the incident and accident investigation form dated

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 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 record review and interview, the facility failed to revise plans to provide comprehensive, resident centered care related to agitation and/or aggression. This affected two (Resident #1 and #24) of six residents reviewed. The facility census was 86. Findings include:1. Review of the medical record revealed Resident #1 was admitted on [DATE] with diagnoses that included but not limited to anxiety disorder, major depressive disorder, and Alzheimer's disease. A care plan dated 05/19/23 revealed Resident #1 was at risk for decline in cognition and had impaired cognitive function or impaired thought processes related to impaired decision making, and impulsivity. Interventions included provide a homelike environment and notify the nurse of any changes in cognitive function.A care plan dated 06/19/24 revealed Resident #1 had an actual behavior problem of hoarding food items such as sour cream, cream cheese, butter and salad dressings in her nightstand. Interventions included, if reasonable, discuss the resident's behavior, explain/reinforce why the behavior is inappropriate and/or unacceptable to the resident.A nurse's note dated 05/24/25 at 9:39 A.M. authored by Licensed Practical Nurse (LPN) #116 revealed Resident #1 became verbally aggressive towards staff today during care. Resident stated, I'm sick of that woman coming in her all the time. Resident #1 was referring to another resident. Resident #1 was easily redirected. Resident #1 let staff provide care and was pleasant. A nurse's note dated 05/24/25 at 10:42 A.M. authored by LPN #116 revealed Resident #1 was agitated and took the nurse to the window and stated Resident #1 was going outside. Resident #1 attempted to stand up and mess with the window. Resident #1 was redirected but became agitated. A nurse's note dated 05/24/25 at 12:02 P.M. authored by LPN #116 revealed Resident #1 attempted to get out of the main doors. Redirection was unsuccessful and Resident #1 was agitated. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had severe cognitive impairment. The MDS also revealed Resident #1 had verbal behaviors directed at others for one to three days during the assessment period.A nurse's note dated 06/06/25 at 6:07 P.M. revealed Resident #1 had a hold of another resident's (Resident #2) arm. A certified nurse assistant (CNA) asked Resident #1 multiple times to let go of Resident #2's arm. When Resident #1 decided to let go of Resident #2, Resident #1 pushed Resident #2 on the floor. Resident #2 fell and hit her head on the floor.A nurse's note dated 06/25/25 at 10:16 A.M. authored by LPN #116 revealed Resident #1 was restless and very agitated. Resident #1 was exit seeking and unable to be redirected. A nurse's note dated 06/25/25 at 1:52 P.M. authored by LPN #116 revealed Resident #1 was very agitated and restless. Resident #1 had set off the door alarms multiple times in the last hour. Resident #1 became more agitated when redirected. Staff attempted to take Resident #1 out for fresh air. Resident #1 grabbed the tables and started yelling. Resident #1 was brought back to the memory care unit because Resident #1 was uncooperative with staff. A nurse's note dated 06/25/25 at 2:54 P.M. authored by LPN #116 revealed Resident #1 was taken outside for fresh air. Resident #1 was cooperative. Resident #1 was currently relaxing and listening to music.An interview on 08/06/25 at 8:46 A.M. Licensed Practical Nurse (LPN) #101 revealed Resident #1 was upset with a family member prior to the incident with Resident #2. An interview on 08/06/25 at 2:28 P.M. Certified Nursing Assistant (CNA) #135 revealed Resident #1 was easily agitated. CNA #135 stated she tried to keep Resident #1 separated from other residents and would put music on that Resident #1 enjoyed. An interview on 08/06/25 at 5:14 P.M. Licensed Nursing Home Administrator (LNHA) verified Resident #1's care plan did not address agitation or aggression. 2. Review of the medical record revealed Resident #24 was admitted on [DATE] with diagnoses that included but limited to Alzheimer's disease, psychosis, major depressive disorder, and adjustment disorder with disturbance of conduct.A care plan dated 04/01/25 revealed Resident #24 was exit seeking and/or wandering. Interventions included to apply a Wander Guard (bracelet to alert caregivers when a resident has wandered from a protected zone) to the right ankle, observe wandering and attempt diversional interventions when wandering into inappropriate locations, and provide structured activities as needed.The quarterly MDS dated [DATE] revealed Resident #24 had severe cognitive impairment. The MDS also revealed Resident #24 had physical and verbal behaviors directed towards others one to three days during the assessment period. A nurse's note dated 03/25/25 at 12:34 P.M. revealed Resident #24 went into another resident's (Resident #14) room. Resident #14 asked Resident #24 three times to leave Resident #14's room. Resident #24 started yelling at Resident #14. Resident #24 then slapped Resident #14 on the abdomen. Resident #14 then slapped Resident #24 on the right arm. A CNA removed Resident #24 from Resident #14's room. The nurse did a skin check and noted

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete neurological checks for Resident #2 after two falls with injuries occurred. This affected one (Resident #2) out of six residents reviewed for incidents with injuries. The facility census was 86.Findings include:Review of the medical record revealed Resident #2 was admitted on [DATE] with diagnoses that included but limited to dementia, degenerative disease of nervous system, major depressive disorder, and generalized anxiety disorder.A change in condition note dated 06/05/25 at 9:16 A.M. revealed Resident #2 was found sitting on the floor in her room. Neurological checks were completed as Resident #2 would allow. A change in condition note dated 06/06/25 at 4:34 P.M. revealed Resident #2 was pushed to the floor by Resident #1. Resident #2 hit the back of her head on the floor. Resident #2 had a laceration to the back of her head. Pressure was applied to the back of Resident #2's head and Resident #2 was transferred to the hospital for evaluation.The hospital records dated 06/06/25 revealed Resident #2 had a 2.5-centimeter irregular contusion to the left posterior occiput. A nurse note dated 06/07/25 at 12:55 A.M. revealed Resident #2 returned to the facility.Review of Certified Nurse Practitioner progress note dated 06/10/25 revealed Resident #2 was shoved by another resident and fell backward and hit her head. The staff reported when Resident #2's head hit the floor; it made a loud sound and there was blood on the floor. Resident #2 was transported to the hospital and medical glue was applied to the left posterior occiput. Resident #2 continued to have hematoma, but staff reported it was beginning to recede. Resident #2 likely had a concussion, and vital signs, neurological checks, fall precautions, and monitoring were to continue per protocol. The significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #2 had severe cognitive impairment. An interview on 08/07/25 at 9:03 A.M. Licensed Nursing Home Administrator (LNHA) verified there was no evidence of neurological checks being done when Resident #2 returned from the hospital on [DATE]. This deficiency is an incidental finding discovered during the complaint investigation.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, schedule review, activity calendar review and interviews, the facility failed to provide comprehensive, resident centered services to ensure dementia care needs were met and promote resident well-being on the specialty unit. This affected two residents (Resident #18 and #24) and had the potential to affect the remaining 20 residents (#1, #2, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #19, #20, #21, #22, #23, #25, and #27) who resided on the specialty care dementia unit. The facility census was 86. Findings include: Review of the staffing schedules revealed on 07/30/25, 07/31/25, and 08/01/25 there was one certified nursing assistant (CNA) and one nurse scheduled to work on the memory care unit. An observation on 08/06/25 at 8:41 A.M. revealed Resident #24 was sitting at a table with a large amount of oatmeal on the underside of her right sweater sleeve. The oatmeal was smeared on the table as the resident moved her arm. At the time of the observation, the nurse was at the nurse's station and the CNA was giving residents showers.An additional observation on 08/06/25 at 9:34 A.M. revealed Resident #24 was still wearing the sweater with oatmeal on the sleeve. An activities calendar in the dining room/activity room revealed activities on 08/06/25 included morning stretches at 9:30 A.M., coffee and daily chronicle at 10:00 A.M., coloring at 11:00 A.M. and snack and chat at 2:00 P.M. An observation on 08/06/25 at 9:34 A.M. revealed residents sitting in the dining/activity room and no staff were in the room. Morning stretches were on the activity schedule to take place at this time. However, the activity was not occurring. An observation on 08/06/25 at 10:43 A.M. revealed a unit manager was in an office on the memory care unit (out of sight of the dining/activity room and hallway) and no other staff were observed. Coffee and daily chronicle were on the activity schedule for 10:00 A.M. and coloring scheduled to begin at 11:00 A.M. There was no observed activity occurring at this time.An observation on 08/06/25 at 2:25 P.M. revealed Resident #18 (female) entered Resident #9 and #10's (males) room. Resident #18 closed the door. This writer knocked and entered the room. Resident #9 was sitting in a chair and Resident #10 was lying in bed. Resident #18 was standing by Resident #10's bed, holding Resident 10's hand. This writer notified the nurse that Resident #18 was in Resident #9 and #10's room. On 08/06/25 at 2:27 P.M. LPN #115 verified Resident #18 should not be in Resident #9 and #10's room. LPN #115 and the CNA were at the nurse's station and were not aware Resident #18 had gone into Resident #9 and #10's room. LPN #115 redirected Resident #18 to the dining/activity room however, there were no activities occurring at that time.An interview on 08/06/25 at 2:28 P.M. with CNA #135 verified there was one nurse and one CNA working on the memory care unit this date. CNA #135 stated a float CNA did come on the unit around lunch time to ask if she needed help passing meal trays but had not been back any other times. CNA #135 verified no one from activities had been on the memory care unit to provide the residents with activities as indicated on the activity schedule. CNA #135 stated she completed nine showers on 08/06/25. CNA #135 verified Resident #24 had oatmeal on her sleeve, but stated other residents had removed incontinence briefs and required showers and assistance and she needed to address those things first. CNA #135 stated Residents #2, #10, #15, and #27 required two staff assist for care and this was difficult with only an aide and a nurse to coordinate when they both could provide care to the residents. An observation on 08/06/25 at 2:39 P.M. revealed activity staff arrived at the memory care unit to make residents root beer floats. Interview on 08/06/25 at 2:41 P.M. with Activities Aide #137 and #160 verified they had not been on the memory care unit until they brought the root beer floats. Activities Aide #137 stated a coffee cart with coffee and juice was provided to the dementia unit and the nursing staff were to provide the residents with the drinks. Coloring pages were printed off and left in the dining room/activity room for residents to color. They stated root beer floats were being provided so the snack and chat was not done at 2:00 P.M. but soft cookies would be provided later. Activities staff verified the scheduled activities on the calendar were not provided as scheduled on 08/06/25.Interview on 08/06/25 at 5:14 P.M. with the Administrator revealed recently there was one CNA scheduled on the memory care unit and one CNA that was to float to the unit as needed. The Administrator (LNHA) stated several staff were pregnant and could not work on the memory care unit, limiting the number of staff they had available to schedule on the memory/dementia care unit. The LNHA revealed there was an activity director and two activity aides and usually one of the activity aides was on the memory care unit to help supervise and provide activities for the residents, but a new activity aide had started and was receiving training off the memory care unit so that support was not always available on the dementia unit despite also having issues with not having adequate nursing staff numbers on the unit. This deficiency represents non-compliance