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	04/09/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to privacy. This affected one resident (Resident #83) out of three residents reviewed for increased staff supervision. The facility census was 84.Findings include:Review of the medical record for Resident #83 revealed an admission date of 12/04/24 with diagnoses of borderline personality disorder, major depressive disorder, anxiety, and insomnia.Review of the care plan dated 07/10/25 revealed Resident #83 had potential for mood fluctuations related to major depressive disorder, anxiety disorder, insomnia, and a history of amputation. Interventions included observing and reporting concerns to the physician, providing oneˆtoˆone monitoring if the resident expressed a desire to harm self or others, following suicide protocol, and notifying the physician.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #83 is cognitively intact and rejects care one to three days each week.Review of the psychiatry note dated 03/10/26 revealed Resident #83 expressed frustration regarding staff monitoring and reported he felt targeted and harassed due to being checked on every 15 minutes. The provider documented the resident had not displayed recent threats or aggressive behaviors, denied suicidal or homicidal ideation, did not appear to be an acute risk to himself or others, and recommended discontinuing the 15ˆminute checks.Review of the psychiatry note dated 03/13/26 revealed Resident #83 was pinkˆslipped (substantial risk of harm to self or others) and transported to the local hospital for medical clearance before being admitted to inpatient psychiatry. Resident #83 denied suicidal or homicidal thoughts, appeared calm and pleasant, expressed hopefulness, and agreed to medication adjustments including a mood stabilizer. The resident was cleared from the pink-slip and discharged back to the facility that same day.Review of the physician orders dated 03/13/26 through 03/16/26 revealed no order for fifteenˆminute checks.Review of behavior monitoring from 03/13/26 through 03/18/26 revealed no behaviors exhibited such as crying, repeated movements, yelling, hitting, pushing, grabbing, biting, abusive language, threatening behaviors or rejection of care. Review of the progress note dated 03/13/26 at 10:33 P.M. revealed Resident #83 returned to the facility. Staff removed potentially harmful objects from the room and initiated fifteenˆminute checks. An order for Depakote (used to stabalize mood) was also started.Review of guest location visual check documentation dated 03/13/26 revealed fifteenˆminute checks were initiated at 8:30 P.M. and continued through 6:45 A.M. on 03/14/26.Review of guest location visual check documentation dated 03/14/26 revealed the fifteenˆminute checks were reinitiated at 3:00 P.M. and continued through 6:45 A.M. on 03/15/26.Review of progress notes dated 03/14/26 at 6:35 A.M. and 2:08 P.M. revealed Resident #83 exhibited no behaviors and expressed frustration about not having access to his personal belongings.Review of the progress note dated 03/14/26 at 2:26 P.M. revealed the unit manager notified staff that Resident #83 could receive his belongings.Review of the progress note dated 03/15/26 at 2:35 P.M. revealed Resident #83 reported headaches, nausea, and feeling like a zombie related to new medication. The resident was educated on his right to refuse medication.Review of the progress note dated 03/16/26 at 12:33 P.M. by Registered Nurse #109 revealed Resident #83 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remained on fifteenˆminute checks until the end of shift and exhibited no behaviors.Interview on 04/09/26 at 11:28 A.M. with the Director of Nursing, Administrator and interim Administrator confirmed the medical record did not contain a physician order for fifteenˆminute checks. They also confirmed the medical record revealed the resident was not exhibiting any concerning behaviors, and reported the hospital cleared him from the pink-slip therefore he was not a safety risk to himself or others, therefore 15 minutes checks were not warranted. Interview on 04/09/26 at 12:10 P.M. with the Administrator revealed that being checked on every fifteen minutes could feel annoying or excessive to some residents and may understandably cause frustration. The Administrator confirmed there was no consistent documentation supporting why the fifteenˆminute checks were initiated or continued. The Administrator also confirmed Resident #83 did not receive his belongings in a timely manner and that the checks continued longer than necessary and up until 03/16/26.Interview on 04/09/26 at 12:16 P.M. with Certified Nursing Assistant (CNA) #144 and Registered Nurse #107 revealed both staff were aware of Resident #83's history, including previous hospital transfers for suicidal ideations. They stated that during the fifteenˆminute checks, staff were instructed to visually confirm the resident's safety by laying eyes on him.Interview on 04/09/26 at 1:05 P.M. with Registered Nurse #109 revealed the fifteenˆminute checks continued until approximately 2:00 P.M. on 03/16/26. The nurse stated Resident #83 was acting normal at that time and there were no safety concerns. The nurse reported the resident often voiced concerns impulsively but believed these concerns should still be taken seriously. The nurse stated Resident #83 tends to have explosive episodes and becomes easily annoyed and did not feel the routine checks were not necessary. This deficiency represents non-compliance investigated under Complaint Number 2791144.