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	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of MT Vernon The	13 Avalon Road Mount Vernon, OH 43050

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, review of fall investigations, staff interview and review of facility policy and procedure, the facility failed to ensure the residents guardian was notified of all falls. This affected two (Resident #39 and #76) of three residents reviewed for falls. The census was 89. Findings include: 1. Review of Resident #76's medical record revealed she was admitted to the facility 07/30/24. Diagnoses included encephalopathy, Alzheimer's Dementia, mood disorder, psychosis, restlessness, agitation, anxiety, suicidal ideation's and major depression. Review of the quarterly Minimum Data Set (MDS(dated 11/06/24 revealed her cognition was not intact. She required set up or clean up assistance with eating, supervision or touching assistance with oral hygiene, and partial/moderate assistance with toileting, shower/bathing, dressing, personal hygiene and turning and repositioning. Resident identified as having falls without major injury. Review of the fall assessment dated [DATE] revealed Resident #76 was at risk for falls. Review of the fall investigations and nursing progress notes revealed Resident #76 had a fall on 08/08/24 at 8:05 P.M She was witnessed sitting down on the floor by a CNA. She was on her hands and knees by the locked door that leads to the 200 hall. She proceeded to go from her knees to her buttocks. There was no documentation the guardian was notified. Review of the fall investigations and nursing progress notes revealed Resident #76 had a fall on 08/14/24 at 10:45 P.M. She was attempting to get up out of the recliner and slid off of the recliner on to the floor on her bottom. There was no documentation the guardian was notified. Review of the fall investigations and nursing progress notes revealed Resident #76 had a fall on 09/02/24 at 6:48 P.M. She was found on the floor in front of her dresser. She was wearing nonslip socks, and stated she was dizzy and fell . There was no documentation the guardian was notified. Review of the fall investigations and nursing progress notes revealed Resident #76 had a fall on 09/12/24 at 9:40 P.M. She placed herself on the floor, somersaulted and stood up. Then walked down the hall. There was no documentation the guardian was notified. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the fall investigations and nursing progress notes revealed Resident #76 had a fall on 09/13/24 at 7:45 P.M. She was on all fours in the hallway, got to her feet, before staff could reach her. She revealed she just slipped. There was no documentation the guardian was notified. Review of the fall investigations and nursing progress notes revealed Resident #76 had a fall on 01/20/25 at 10:20 P.M. She was found on the floor by a walker. She could not recall what happened or what she was trying to do. There was no documentation the guardian was notified. Interview on 02/05/25 at 2:04 P.M. with Director of Nursing verified there was no evidence Resident #76's guardian was notified of the falls. Review of the Notification of Change policy and procedure dated 12/19/22 revealed a change in status would include an accident involving the resident, revealed changes in the residents status or any unusual occurrences, the licensed nurse will notify the residents representative, unless otherwise dictated by the resident. 39333 2. Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses included but not limited to Huntington's disease, generalized anxiety disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #39 had severely impaired cognition and was dependent for activities of daily living (ADLs). Review of the fall investigation dated 10/24/24 revealed Resident #39 was found on the floor between the bed and the wall. Fall investigation stated that no notifications were found under the section of agencies/people notified. Interview on 02/05/25 at 3:17 P.M. with Director of Nursing (DON) verified that notification was not given to power of attorney (POA) in reference to the unwitnessed fall on 10/24/24.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, observation and staff interview, revealed the facility failed to ensure accuracy of assessments. This affected one (Resident #47) of two residents reviewed for dental assessments. The census was 89. Findings include: Review of Resident #47 revealed they were admitted on [DATE]. Diagnoses included alcoholic cirrhosis of the liver, alcohol dependence with alcohol induced persisting dementia, acute kidney failure, viral hepatitis C, severe protein calorie malnutrition, and anxiety. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed his cognition was not intact, was independent with eating, turning and reposition, required supervision or touching assistance with oral hygiene, toileting, bathing/showering, dressing and personal hygiene, with no obvious or likely cavity or broken natural teeth. Observation on 02/03/25 at 3:49 P.M. revealed his lower teeth were broken and missing with decay of teeth. Interview on 02/05/25 at 2:04 P.M. with Director of Nursing verified the Admission MDS for 11/25/24 was incorrect in regard to Resident #47's dental status. On 02/05/25 at 2:33 P.M. Interview with Social Service Assistant #335 revealed the resident's dentist comes to the facility quarterly and was last at the facility on 12/04/24. She revealed Resident #47 had not been referred to her to see the dentist and she was not aware of any dental issues. On 02/06/25 at 10:28 A.M. observation of Resident #47's teeth revealed broken, missing and decay of the teeth. This was verified with Licensed Practical Nurse #213 at the time of the observation and she asked him if he had seen a dentist since he had been here and he revealed he has not.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, observation and staff interview, the facility failed to develop a comprehensive care plan for Resident #47's dental needs. This affected one (Resident #47) of two residents reviewed for dental care. Findings include: Review of Resident #47 revealed they were admitted on [DATE]. Diagnoses included alcoholic cirrhosis of the liver, alcohol dependence with alcohol induced persisting dementia, acute kidney failure, viral hepatitis C, severe protein calorie malnutrition, and anxiety. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed his cognition was not intact, was independent with eating, turning and reposition, required supervision or touching assistance with oral hygiene, toileting, bathing/showering, dressing and personal hygiene, with no obvious or likely cavity or broken natural teeth. Review of Resident #47's medical record revealed no evidence the facility developed a comprehensive care plan for dental care. Observation on 02/03/25 at 3:49 P.M. revealed his lower teeth were broken and missing with decay of teeth. On 02/05/25 at 2:33 P.M. Interview with Social Service Assistant #335 revealed the dentist comes to the facility quarterly and was last at the facility on 12/04/24. She revealed Resident #47 had not been referred to her to see the dentist and she was not aware of any dental issues. She also revealed she thinks nursing would be responsible for the dental plan of care and verified Resident #47 did not have a dental plan of care.

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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** 39333 Based on medical record review, observation and staff interview, the facility failed to ensure pressure reduction interventions were in place at all times for Resident #53. This affected one resident (Resident #53) of three residents reviewed for pressure ulcer prevention. Findings include: Review of the medical record for Resident #53 revealed an admitted [DATE] with diagnoses including but not limited to injury of left Achilles tendon, muscle wasting, and bradycardia. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #53 had moderately impaired cognition, required dependent for activities of daily living (ADLs) and had a surgical wound. Review of the care plan dated 01/08/25 revealed Resident #53 was at risk for impaired skin integrity. Interventions included but not limited to encourage to float heels while in bed and assist as needed. Review of the physician's orders for February 2025 revealed an order for heel elevation boots to bilateral feet while in bed, as guest tolerates. Observation on 02/03/25 at 11:00 A.M. revealed that Resident #53 was not wearing her boots. Interview at time of observation with Licensed Practical Nurse (LPN) #385 verified that Resident #53 did not have elevation boots on her feet. Review of the facility policy with an effective date of 09/19/24 titled, Skin Management, revealed that practice guidelines state residents admitted with skin impairment will have appropriate interventions implemented to promote healing.

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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** 51074 Based on observation, medical record review and interview the facility failed to ensure fall interventions were in place for Resident #60. This affected one resident (Resident #60) of one reviewed for falls. The facility census was 89. Findings include: Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnoses including end stage renal disease, obstructive uropathy, chronic kidney disease stage four, osteoarthritis, major depressive disorder and paroxysmal atrial fibrillation. Review of Resident #60 dated 10/26/23 revealed Resident #60 was at risk for fall related injury and falls related to muscle weakness with limited mobility and end stage renal disease (ERSD), psychoactive medication use antidepressant for depression, antianxiety for anxiety. Interventions included activities to access for in-room activities and preferences, encourage the resident to wear appropriate footwear, call light within reach, commonly used items within reach, move closer to nurses' station for closer observation by staff; observe for fatigue and/or unsteadiness and encourage rest periods as needed; offer resident to get up in wheelchair, when restless, perimeter mattress to bed at all times, nonskid strips to right side of bed, visual cues to remind resident to ask for assistance for transfers. Review of fall investigation report dated 01/06/25 revealed resident was ambulating to the bathroom and while attempting to open the door, his hand slipped off the handle and he fell , landing on his left shoulder. gripper socks were in place. The new intervention was to move his room closer to the nurses' station. Review of Resident #60 quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating mild cognitive impairment. The resident was assessed to require set up for meals and substantial assistance for activity of daily living (ADL'S) such as dressing, personal hygiene and bathing. Resident #60 required moderate assistance for bed mobility and transfers. Resident #60 utilized a wheelchair for mobility. Resident # 60 experienced a fall prior to admission and experienced two falls since admission to the facility, one with major injury and one without injury. On 02/05/25 at 11:43 A.M. Resident #60 was observed resting in bed. The non-skid strips were not observed on the floor and there were no visual signs posted to remind Resident #60 to ask for help. On 02/05/25 at 11:52 A.M. interview with Licensed Practical Nurse (LPN)# 266 confirmed non-skid strips were not in place and there was no signage reminding the resident to ask for help. Review of fall policy dated 05/01/10, revised 09/22/23, revealed the interdisciplinary team will review all the resident falls within 24-72 hours and at the clinical operations meeting to evaluate/investigate the circumstances and probable cause for the fall, review/modify the plan of care to minimize repeat falls and link to the resident's Kardex as needed.

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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** 47569 Based on observations, medical record review, interview, and facility policy review the facility failed to ensure proper storage of Resident #8 and Resident #78 respiratory equipment, and failed to implement an order for a breathing improvement device for Resident #286. This affected three residents (Resident #8, Resident #78, and Resident #286) out of four residents reviewed for respiratory care. The facility census was 89. Findings Include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE] and re-admitted [DATE] with the following diagnoses including but not limited to acute respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), sleep apnea, and type two diabetes mellites. Resident #8 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of nine out of a possible 15. Resident #8 required assistance for completion of Activities of Daily Living (ADLs) tasks including medication administration and the use of a wheelchair for mobility. Review of Resident #8's physician orders revealed an order dated 12/04/24 for Oxygen (02) 4 liters per minute via nasal cannula to maintain 02 blood saturation (SP02) between 88% to 92% every day and night shift for shortness of breath. Review of Resident #8 Medication Administration Record (MAR) dated 01/01/25 to 01/31/25 revealed the completed order for Oxygen (02) 4 liters per minute via nasal cannula to maintain 02 blood saturation (SP02) between 88% to 92% every day and night shift for shortness of breath. Review of Resident #8's SP02 readings dated 01/21/25 to 02/02/25 revealed SP02 results ranged from 93% to 98%. Review of Resident #8's admission Minimum Data Set (MDS) dated [DATE] revealed Section O - Special Treatments, Procedures, and Programs was marked as Resident #8 using oxygen therapy. An observation on 02/03/25 from 10:00 A.M. to 11:15 A.M. revealed Resident #8 sitting at a table in the lounge/activity room in a wheelchair. There was an oxygen concentrator plugged into the wall behind where Resident #8 was sitting at the table. There was oxygen tubing attached to the concentrator which was laying on the floor and stretched across the aisle to where Resident #8 sat in the wheelchair with the nasal cannula in place. The concentrator was set at 4 liters. There was a portable oxygen tank in a storage bag hanging on the back of Resident #8's wheelchair. A review of the facility policy titled, Use of Oxygen dated 08/17/21 revealed, To promote guest/resident safety in administration of oxygen. The tubing should be kept off the floor. An interview on 02/03/25 at 11:22 A.M. with the Director of Nursing (DON) confirmed Resident #8 was sitting at a table in the lounge/activity room with the oxygen concentrator plugged into the wall with the oxygen tubing laying on the floor and stretched across the aisle. The DON stated the oxygen tubing should be off the floor and secured in a bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51074 2. Review of the medical record for Resident #78, revealed an admitted [DATE]. Diagnoses included trisomy 21 (down syndrome), hypothyroidism, pulmonary embolism, displaced bimalleolar fracture of the right lower leg, Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of one out of 15 indicating severe cognitive impairment. The resident was assessed and required set up with meals and dependent on staff for all other activities of daily living (ADL's) such as bathing, dressing, hygiene, bed mobility and transfers. Review of Resident #78's plan of care dated 01/12/25 for a potential difficulty breathing and at risk for respiratory complications. Interventions included administer medications and treatment as ordered by physician, monitor for ineffectiveness, side effects and adverse reactions, report abnormal findings to the physician. Oxygen as needed, nebulizer as ordered, pulse pximetry, elevate head of bed, identify and eliminate sources of respiratory irritation such as cigarette smoke, pollen, perfumes, observe for difficulty breathing (dyspnea) on exertion. Observe for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, somnolence. Report abnormal findings to the physician. Review of Resident #78's physician orders revealed Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (three) milligrams/ milliliter (MG/ML) (Ipratropium-Albuterol) three ml inhale every six hours as needed for shortness of breath or wheezing, oxygen one to three liters per minute by nasal cannula as needed for short of breath and to maintain oxygen saturation greater than 92%. On 02/03/25 at 01:49 P.M. observation of Resident #78 room revealed respiratory equipment laying in the chair without a bag. On 02/04/25 at 08:40 A.M., observation was made of a nebulizer and oxygen concentrator in Resident #78 room. Tubing for the nebulizer and oxygen mask was laying in the chair beside the bed without a bag, and the resident's oxygen nasal cannula was observed on the floor. On 2/04/25 at 10:24 A.M., interview with certified nursing assistant (CNA) #256 confirmed tubing should be in a bag not lying in chair or hanging off of concentrator. On 02/04/25 at 12:00 P.M., interview with Director of Nursing (DON) confirmed oxygen equipment and tubing should be in a bag and not laying in the chair or on the floor. Review of the facility policy Use of Oxygen revised 01/17/21 revealed oxygen tubing should be changed and dated weekly. The tubing should be kept off the floor. The oxygen cannula or mask, when not in use, should be stored in a clean bag. Bags should be changed weekly. 3. Review of the medical record for Resident #286 revealed an admitted [DATE] with diagnoses including influenza A and pneumonia, unspecified organism. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 01/29/25 revealed interventions to observe for signs and symptoms of respiratory infection: elevated temp, change in level of consciousness, malaise, chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (dyspnea), increased coughing and wheezing. Report abnormal findings to the physician. Review of physician orders revealed orders for Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) milligram per activation (MCG/ACT) two puffs: inhale every six hours as needed for shortness of breath or wheezing and droplet precautions dated 01/29/25 for influenza A. Review of Resident #286's physician orders, Medication Administration Record, and Treatment Administration Record for January through February 2025 revealed no order for a Aerobika device or incentive spirometer. On 02/04/25 at 10:13 A.M. observation of Resident #286's room revealed he had a Aerobik oscillating positive expiratory pressure device (a medical device used to improve airway clearance and reduce symptoms in patients with respiratory conditions) and incentive spirometer (a handheld medical device used to help patients improve the functioning of their lungs) on Resident #286 over the bed table. Resident # 286 demonstrated how it is used and stated he uses the Aerobika twice a day. Interview on 02/04/25 at 10:53 A.M. with Assistant Director of Nursing (ADON) #391 confirmed there were no orders for Aerobika or incentive spirometer were present in physicians orders or plan of care and she was unaware he had them.

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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** 47569 Based on medical record review, interview and facility policy review the facility failed to ensure non-pharmacological pain interventions were implemented for one resident. This affected one resident (Resident #237) out of two residents reviewed for pain management. The facility census was 89. Findings Include: A review of Resident #237's medical record revealed admitted [DATE] with the following diagnoses including but not limited to acute kidney failure, pulmonary emboli (clot), alcohol abuse, bipolar disorder, and weakness. Resident #237 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 14 out of a possible 15 dated 01/22/25. Resident #237 required assistance from staff to complete Activities of Daily Living (ADL) tasks including transfers and personal hygiene tasks. Resident #237 was non-ambulatory and used a wheelchair for mobility. A review of Resident #237's physician orders revealed an order dated 01/22/25 with a revision date of 02/04/25 for pain medication Oxycodone HCL oral tablet 10 milligrams (MG) give one tablet by mouth every four hours as needed (PRN) for pain. The revision of this order was the addition of document non-pharmacological interventions used: 1) Massage, 2) Meditation/Relaxation, 3) Positioning, 4) Ice/cold pack, 5) Diversional Activity, 6) Guided imagery, 7) Rest, 8) social interaction. A review of Resident #237's Medication Administration Record (MAR) dated 01/15/25 to 01/31/25 revealed Resident #237 was administered PRN pain medication Oxycodone on the following dates; 01/22/25 two times, 01/23/25 two times, 01/24/25 three times, 01/25/25 two times, 01/26/25 two times, 01/27/25 two times, 01/28/25 three times, 01/30/25 two times, and 01/31/25 four times. There was no documentation of non-pharmacological interventions being attempted or provided prior to the administration of the pain medication Oxycodone. A review of Resident #237's MAR dated 02/01/25 to 02/05/25 revealed Resident #237 was administered on the following dates; 02/01/25 one time, 02/02/25 two times, 02/03/25 three times there was no documentation of non-pharmacological interventions being attempted or provided prior to the administration of the pain medication Oxycodone. Following the revision of the order dated 02/04/25, Resident #237 was administered the PRN pain medication Oxycodone one time on 02/04/25 and on 02/05/25 the non-pharmacological interventions were marked as nonapplicable (NA). A review of Resident #237's admission evaluation and baseline care plan dated 01/16/25 revealed the pain interview with Resident #237 was marked as generalized pain with pain level of 10 out of 10 possible pain scale. Non-pharmacological interventions included rest and medication for relieving the pain. A review of Resident #237's Plan of Care (POC) dated 01/17/25 revealed Resident #237 was at risk for pain related to weakness, impaired mobility, bipolar disorder, and history of alcohol abuse. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/05/25 at 1:37 P.M. with the Director of Nursing (DON) confirmed there were no non-pharmacological interventions documented on the initial pain medication Oxycodone order dated 01/22/25. The DON also confirmed the revised order dated 02/04/25 did have the non-pharmacological interventions added to the order with documentation marked as NA on Resident #237's MAR dated 02/04/25 and 02/05/25. The DON stated when pain medication orders are implemented there should be non-pharmacological interventions included and should be attempted and documented prior to administering the pain medication. Review of the facility's policy titled, Pain Management revised 04/11/23 revealed, Individualized interventions related to that resident's individual control of pain management should include both pharmacological, non-pharmacological and include Complementary and Alternative Medicine (CAM) pain management interventions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51074 Based on observation, interview, review of medications manufactures guidelines, and facility policy review the facility failed to ensure medication was dated and discarded properly. This affected six residents (Resident #12, Resident #39, Resident #48, Resident #136, Resident #139, and Resident #290) out of 22 residents reviewed for medication storage and had the potential to affect all 89 residents in the facility. Findings include: 1. On 02/05/25 at 9:00 A.M. observation of the medication storage area for the 300-400 hall revealed the following: Resident #12 had an opened bottle of Morphine Sulfate (concentrate) solution 20 milligrams per milliliter (MG/ML), give 0.25 ml by mouth every hour as needed for pain. Per the pharmacy label, the medication was dispensed on 01/24/25 however, the bottle was not dated when it was opened. Resident #39 had Morphine Sulfate (concentrate) solution 20 milligrams per MG/ML, give 0.25 ml by mouth every hour as needed for pain. Per the pharmacy label, the medication was dispensed on 01/25/25, however the bottle was not dated when opened. On 02/06/25 at 09:00 A.M., interview with Registered Nurse (RN) #284 confirmed medications were not dated when opened. 2. On 02/06/25 at 09:30 A.M. observation of the medication storage area for 200 hall revealed the following: Resident #48 had an opened bottle of Cromolyn 4% ophthalmic solution (used in the eye to treat certain disorders of the eye caused by allergies). According to the pharmacy storage guide the medication was dispensed on 11/11/24, and the bottle was labeled with an open date of 11/19/24. According to manufacturers' insert provided in the box with the medication, the medication should be discarded 30 days after opening. The medication storage room had a multi vial Tuberculin purified protein derivative dispensed on 01/30/25 and the vial was not dated when opened. According to manufacturers' insert located in the box with the vial revealed the vial should be discarded 30 days after opening/expires 30 days after opening (and should be discarded). Review of new admission since the date the Tuberculin was dispensed reveaeld Resident #290, Resident 139, Resident # 136 were admitted since 01/30/25. On 02/06/25 at 09:30 A.M., interview with Licensed Practical Nurse (LPN) #395 confirmed the Cromolyn eye solution and the tuberculin was not dated when they were opened.

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	365404	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of MT Vernon The	13 Avalon Road Mount Vernon, OH 43050

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on medical record review and interview the facility failed to ensure laboratory testing was completed for residents. This affected one resident (Resident #237) out of five residents reviewed for use of unnecessary medications. The facility census was 89. Findings Include: A review of Resident #237's medical record revealed admitted [DATE] with the following diagnoses including but not limited to bacteremia, acute kidney failure, pulmonary emboli (clot), alcohol abuse, bipolar disorder, and weakness. Resident #237 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 14 out of a possible 15 dated 01/22/25. Resident #237 required assistance from staff to complete Activities of Daily Living (ADL) tasks including transfers and personal hygiene tasks. Resident #237 was non-ambulatory and used a wheelchair for mobility. A review of Resident #237's physician's history and physical progress note dated 01/21/25 authored by the facility's medical director revealed laboratory tests requested for Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) for Resident #237 to be completed on 01/23/25. A review of Resident #237's physician orders dated 01/16/25 to 01/31/25 revealed there were no orders for laboratory tests CBC and BMP to be completed on 01/23/25. A review of Resident #237's Treatment Administration Record (TAR) dated 01/16/25 to 01/31/25 revealed there were no orders marked as completed for laboratory tests CBC and BMP on 01/23/25 or on any day following. A review of the facility's laboratory forms revealed there were no laboratory forms completed for Resident #237 dated 01/23/25. An interview on 02/06/25 at 8:55 A.M. with Licensed Practical Nurse (LPN) #290 revealed when the physician orders are reviewed and laboratory tests are ordered, the nurse will complete the laboratory test sheet with the resident's information and will mark the laboratory tests which were ordered. The order and the laboratory form will be faxed to the laboratory. The laboratory staff will make rounds at the facility and will complete the laboratory form to reflect when the laboratory test was obtained. The laboratory results are faxed to the facility and the facility will notify the physician or certified nurse practitioner (CNP) which ordered the laboratory tests. If the laboratory tests had not been obtained, the physician is notified, and the laboratory tests are rescheduled for another day. An interview on 02/05/25 at 9:01 A.M. with the Director of Nursing (DON) confirmed the laboratory tests (CBC and BMP) which had been ordered on 01/23/25 by the facility medical director had not been completed and had not been rescheduled for another day to be obtained.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, observation and staff interview, revealed the facility failed to ensure routine dental services were in place for Resident #47. This affected one (Resident #47) of two residents reviewed for dental care. The census was 89. Findings include: Review of Resident #47 revealed they were admitted on [DATE]. Diagnoses included alcoholic cirrhosis of the liver, alcohol dependence with alcohol induced persisting dementia, acute kidney failure, viral hepatitis C, severe protein calorie malnutrition, and anxiety. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed his cognition was not intact, was independent with eating, turning and reposition, required supervision or touching assistance with oral hygiene, toileting, bathing/showering, dressing and personal hygiene, with no obvious or likely cavity or broken natural teeth. Observation on 02/03/25 at 3:49 P.M. revealed his lower teeth were broken and missing with decay of teeth. Interview on 02/05/25 at 2:04 P.M. with Director of Nursing verified the Admission MDS for 11/25/24 was incorrect in regard to Resident #47's dental status. On 02/05/25 at 2:33 P.M. interview with Social Service Assistant #335 revealed the resident's dentist comes to the facility quarterly and was last at the facility on 12/04/24. She revealed Resident #47 had not been referred to her to see the dentist and she was not aware of any dental issues. She also said she thinks nursing would be responsible for the dental plan of care. On 02/06/25 at 10:28 A.M. observation of Resident #47's teeth revealed broken, missing and decay of the teeth. This was verified with Licensed Practical Nurse #213 at the time of the observation and she asked him if he had seen a dentist since he had been here and he revealed he has not.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39333 Based on observation and staff interview the facility failed to maintain a clean and sanitary environment for Resident #15, #16, #27, and #73. This four residents (#15, #16, #27, and #73) our of 19 residents reviewed for environment. Findings include: Observation on 02/03/25 at 10:30 A.M. revealed that Resident #73's privacy curtain had black marks and blue stains on it. This was verified by Certified Nursing Assistant (CNA) #260 on 02/03/25 at 10:31 A.M. An environmental tour was conducted with the Administrator on 02/06/25 between 9:03 A.M. and 9:30 A.M. which revealed the rooms belonging to Residents #15, #16, and #27 contained privacy curtains that were stained to various degrees by unknown substances. These findings were observed and verified by the Administrator during the environmental tour. Review of the housekeeping schedule revealed that resident rooms are scheduled to be deep cleaned every 30 to 45 days.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. 39333 Based on observations and interviews the facility failed to ensure the smoking area was maintained in a clean and safe manner. This had the potential to affect all 89 residents. Findings include: Observation on 02/03/25 at 12:03 P.M. of the smoking area located in the courtyard revealed a smoking area not maintained properly. There were numerous cigarette butts located on the ground and not in the designated ashtrays. Observation on 02/06/25 at 9:18 A.M. with the Administrator revealed that there were approximately 25 cigarette butts around the courtyard and a pile of cigarette butts that looked like someone dumped an ashtray on the ground. Interview on 02/06/25 at 9:18 A.M. with the Administrator verified the condition of the smoking area located in the courtyard. Review of the undated facility policy titled, Smoking Policy, revealed the facility permits smoking in the designated area outside the facility, compliant with state regulations. Review of the facility document revealed the facility did not implement the policy.