

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER The Laurels of Heath		STREET ADDRESS, CITY, STATE, ZIP CODE 717 South 30th Street Heath, OH 43056	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801</p> <p>Based on closed medical record review, review of the wound nurse practitioner (NP) progress notes, and interviews the facility failed to ensure wound notes were accurately documented to reflect current treatment orders for skin alterations. This affected one resident (#1) of three record reviewed.</p> <p>Findings included:</p> <p>1. a. Closed medical record revealed Resident #1 was admitted to the facility initially on 03/07/24 and readmitted on [DATE] with diagnoses including tracheostomy, embolism and thrombosis of deep veins of left upper extremity, acute respiratory failure, quadriplegia, dependence on respirator, and Raynaud's.</p> <p>Review of Resident #1's Wound NP #500's progress note dated 07/26/24 revealed new orders to cleanse the right scapula wound with 3% acetic acid.</p> <p>Review of Resident #1's orders revealed no evidence 3% acetic acid was ordered to cleanse the wound.</p> <p>Interview on 09/10/24 at 4:35 P.M., with the Director of Nursing (DON) and Wound Licensed Practical Nurse (WLPN) #224 revealed the facility never received the order for 3% acetic acid. The WLPN #224 and DON reported the Wound NP #500 gives staff verbal orders and the staff enter the orders into the electronic medical record. The DON reported some of the orders were signed by the Wound NP #500, however some were signed by the resident's physician.</p> <p>Interview on 09/10/24 at 4:45 P.M., with Wound NP #500 revealed she gets distracted and may have documented the order inaccurately and would probably go by the orders the staff had entered more likely.</p> <p>b. Review of Resident #1's Wound NP #500's progress note dated 07/26/24, 08/02/24, and 08/09/24 revealed the resident had venous ulcers on left lateral lower leg proximal and left lower leg distal. New orders written to wrap with ace bandages daily as tolerated.</p> <p>Review of Resident #1's orders revealed no evidence ace bandages to the lower extremities was ever ordered.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 09/10/24 at 4:35 P.M., with the DON and WLPN #224 revealed the facility never received the order to wrap the lower legs with ace bandages daily.</p> <p>Interview on 09/10/24 at 4:45 P.M., with Wound NP #500 revealed she gets distracted and may have documented inaccurately and would probably go by the orders the staff had entered more likely. The Wound NP #500 reported initially she wanted ace wraps but then determined it would not be beneficial.</p> <p>c. Review of Resident #1's Wound NP #500's progress note dated 08/02/24 revealed to cleanse the right head, right lateral calf, right and left scapula with 1/2 strength Dakin's solution.</p> <p>Review of Resident #1's orders revealed no evidence the 1/2 strength Dakin's solution was ordered.</p> <p>Interview on 09/10/24 at 4:35 P.M., with the DON and WLPN #224 revealed the facility never received the order for 1/2 strength Dakin's solution.</p> <p>Interview on 09/10/24 at 4:45 P.M., with Wound NP #500 revealed she gets distracted and may have documented inaccurately and would probably go by the orders the staff had entered more likely.</p> <p>d. Review of Resident #1's Wound NP #500's progress note dated 08/09/24 revealed to cleanse the sacrum with 1/2 strength Dakin's solution.</p> <p>Review of Resident #1's orders dated 08/09/24 revealed the order was changed to cleanse the sacrum wound with house wound cleanser.</p> <p>Interview on 09/10/24 at 4:35 P.M., with the DON and WLPN #224 revealed the resident's wound was originally being cleansed with Dakin's solution and the Wound NP #500 gave verbal orders on 08/09/24 to change to house wound cleanser.</p> <p>Interview on 09/10/24 at 4:45 P.M., with Wound NP #500 revealed she gets distracted and may have documented inaccurately and would probably go by the orders the staff had entered more likely.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156945.</p>		