STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365598	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of West Carrollton The	115 Elmwood Circle West Carrollton, OH 45449

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 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** Based on record review, staff interviews, observations and policy review, the facility failed to ensure durable medical equipment i.e. bedside commode was in good repair which resulted in resident experiencing an avoidable fall. Additionally, the facility failed to ensure a thorough fall investigation was completed following a residents fall. This affected one (#12) out of three residents reviewed for falls. The facility census was 76. Findings include: Review of medical record for Resident #12 revealed admission date of 05/2/25. Diagnoses include depression, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), severe kyphosis, osteoarthritis, osteopenia, and history of compression fractures. Resident #12 remained in the facility. Review of Resident #12's care plan dated 10/08/25 revealed the resident was at risk for fall related injury and falls related to weakness, incontinence, use of psychotropic medication for depression and history of falls. Review of Resident #12's Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. She was independent with eating, required moderate assistance with bed mobility and transfers and was dependent upon staff for toileting hygiene. Documentation revealed she had one fall during the lookback period. Review of Resident #12's nurses notes dated 01/02/26 at 9:36 A.M. revealed the resident had a fall on 01/01/26 while on the bedside commode. Resident #12 was sent to the emergency room for evaluation and treatment. New interventions for Physical/Occupational Therapy related to transfers and toileting. Care plan updated. Review of the emergency room documentation revealed Resident #12 presented on 01/01/24 following a mechanical fall in which Resident #12 fell through a bedside commode after the bucket fell out and she became stuck. Following evaluation, Resident #12 returned to the facility. Review of Resident #12's Interdisciplinary Team (IDT) note dated 01/02/26 documented a fall while on the bedside commode on 01/01/26. Resident #12 was sent to the emergency room for further evaluation and treatment. Review of the fall packet revealed the factors observed at the time of the fall documented a check mark in the equipment malfunction box. The description of the observation documented, bedside commode collapsed in and resident was stuck in the device yelling for help. The fall summary documented Resident #12 was stuck on commode following a self-transfer. The packet documented, the bedside commode was unstable (was taped together) prior to resident using bedside commode. The document was signed by Licensed Practical Nurse (LPN) #106. Interview on 03/19/26 at 9:12 A.M. with Certified Nursing Assistant (CNA) #102 revealed she was assigned to Resident #12 the day of her fall on 01/01/26. CAN #102 revealed she entered the room after the nurse had assisted Resident #12 back to bed. CNA #102 explained she saw tape on the bedside commode and stated it was not sturdy equipment. CNA #102 verified management had not spoken to her to request a statement of the fall, ask her knowledge who taped the commode and/or who placed it in the room for use and the overall condition of the commode. Interview on 03/19/26 at 10:22 A.M. with LPN #106 revealed she was working on 01/01/26 when she heard Resident #12 yelling for help from her room. LPN #106 entered the room to find Resident #12 folded up in the commode. LPN #106 stated she helped to remove Resident #12 from the commode, assessed her for injury before pivoting her to the (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. LPN #106 encouraged Resident #12 to be evaluated at the emergency room and emergency services were called. LPN #106 explained upon inspection of the commode she observed the thin bar that holds the bucket was taped with surgical tape where it connected to the front of the bedside commode frame. LPN #106 stated the thin bar gave way when Resident #12 sat on the commode seat and she became stuck when the bucket frame gave way. LPN #106 added the commode should have never been in the room for use as it was unstable. LPN #106 stated she removed the commode from the room and placed it in the hallway for maintenance to dispose of. LPN #106 revealed she filled out the fall investigation packet for Resident #12's fall on 01/01/26. LPN #106 verified no management had followed up with her regarding the fall and/or the condition of the commode. Interview on 03/19/26 at 12:01 P.M. with the Director of Nursing (DON) verified Resident #12 had fall due to an issue with a bedside commode. The DON denied she had observed the commode herself and denied knowledge the commode had been taped. The DON explained Maintenance Director (MD) #103 had disposed of the commode when he arrived to work the morning of the fall. After reviewing the fall packet, the DON acknowledged there was documentation the commode had been taped. The DON stated after the incident staff went through the facility to ensure equipment was in good repair. The DON acknowledged there was no investigation as to what staff member taped the commode and/or left the mechanically unsecure equipment in Resident #12's room for her use nor what to do with mechanically unstable equipment. Interview on 03/19/26 at 12:14 P.M. with MD #103 revealed when he came to work on 01/03/26 the bedside commode was in the hallway outside of Resident #12's room. MD #103 explained someone had taped the front cross bracing that holds the bucket with surgical tape. MD #103 verified the commode was mechanically unsecure. MD #103 disposed of the commode and did rounding on additional residents' equipment to ensure its integrity. Observations of an undated photograph identified as Resident #12's bedside commode revealed the seat and lid of the device were in the upright position. Looking at the front of the commode, the left side of the bucket frame appeared intact. The right side of the frame presented with a piece of surgical tape attached and was fully detached from the main frame of the bedside commode. The facility policy, Fall Management revised 07/08/25 documented the IDT team would review all resident falls within 24072 hours and evaluate/investigate the circumstances and probable cause for the fall. This deficiency represents non-compliance investigated under Complaint Number 2727577.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to ensure weights were obtained and monitored in accordance with facility policy. This affected one (#11) of three residents reviewed for nutrition. The facility census was 76. Findings include: Review of medical record for Resident #11 revealed admission date of 11/29/26. Diagnoses include Alzheimer's Disease, unstageable pressure ulcer of sacral region, metabolic encephalopathy, congestive heart failure and essential tremor. The resident was hospitalized on [DATE] and did not return. Review of Resident #11's admission Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview Mental Status (BIMS) score of 10 indicating impaired cognition. He required moderate assistance with eating and was dependent upon staff for toileting hygiene, bed mobility and transfers. Review of Resident #11's weights revealed weights were obtained on 11/19/25 at 164 pounds (lbs), 12/01/25 at 165.2 lbs and 12/08/25 at 164.2 lbs. No other weights were documented for Resident #11 and the resident discharged to the hospital on [DATE] Interview on 03/18/26 at 2:19 P.M. with Unit Manager (UM)#107 revealed unless otherwise ordered for medical reasons a resident should be weighed up on admission, weekly for four weeks and then monthly. UM #107 verified Resident #11 was weighed on 11/19/25 upon his admission, on 12/01/25 and again on 12/08/25. UM #107 verified no other weights were documented for Resident #11 and the resident discharged to the hospital on [DATE]. Review of the facility policy, Weight Management revised 07/30/25 documented all residents would be weighed on admission, weekly for four weeks and monthly or as indicated by the physician. This deficiency represents non-compliance investigated under Complaint Number 2709811.