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	05/19/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, observation, staff interviews, and policy review, the facility failed to administer medication as ordered. This affected one (#62) resident out of four reviewed for medication administration. The facility census was 79.Findings include: Review of the medical record for Resident #62 revealed an admission date of 06/01/24 with medication diagnoses of bipolar disorder, depression with psychotic features, Diabetes Mellitus (DM), paranoid schizophrenia, and hypertension.Review of Resident #62's quarterly Minimum Data Set (MDS) assessment, dated 04/28/26, revealed Resident #62 was cognitively intact and required substantial/maximum staff assistance with toilet hygiene, was dependent upon staff for bathing, and was independent with bed mobility and transfers. Review of Resident #62's physician orders revealed orders dated 03/30/26 for Depakote (anticonvulsant) 25 mg one tablet by mouth daily, Losartan Potassium (used to treat high bloodpressure) 100 mg one tablet by mouth daily, Potassium Chloride (electrolyte supplement) 20 milliequivalent (meq) one tablet by mouth daily, Metformin (used to treat DM) 500 mg one tablet by mouth two times per day, and a multivitamin one tablet by mouth daily. Further review of physician orders revealed orders dated 04/08/26 for Claritin (antihistamine) 10 milligram (mg) one tablet by mouth daily and orders dated 05/16/26 for Ativan (antianxiety) 0.5 mg one tablet by mouth daily and Risperdal (antipsychotic medication)0.5 mg one tablet every morning. Observation on 05/18/26 at 9:15 A.M. revealed Registered Nurse (RN) #210 prepared medications for Resident #62 by placing Ativan, Depakote, Metformin, Potassium Chloride, multivitamin tablets into a medication cup. RN #210 was observed to place Claritin and Losartan tablets into her bare hands prior to placing the medications into the medication cup. The observation revealed RN #210 could not administer Risperdal as ordered because the medication was not available from pharmacy. RN #210 gave the medications to Resident #62 and observed the resident consume the medications. Interview on 05/18/26 at 9:29 A.M. with RN #210 confirmed she had not administered Resident #62's Risperdal 0.5 mg one tablet as ordered because the medication had not been delivered from the pharmacy and was not available for administration. RN #210 confirmed the Risperdal 0.5 mg tablet had not been administered as ordered on 05/16/26, 05/17/26, and 05/18/26. Interview on 05/19/26 at 7:42 A.M. with Director of Nursing (DON) confirmed Resident #62's medical record did not have documentation to support the Risperdal 0.5 mg tablet was administered as ordered on 05/16/26, 05/17/26, and 05/18/26. DON stated the medication had not been delivered by the pharmacy and the facility had notified the pharmacy several times of the Risperdal 0.5 mg not available for administration. DON confirmed that the medical record did not have documentation to support the physician was notified the medication was not available for administration. DON stated Risperdal was available in the facility emergency locked box for administration when not available from the pharmacy. Review of the facility policy titled, Medication Administration, revised 10/17/24 stated resident medications are to be administered in an accurate, safe, timely, and sanitary manner. The policy stated medications are to be administered in accordance with written orders of the attending physician. The policy stated staff are to perform hand hygiene prior to medication preparation for each medication pass and perform hand hygiene after direct resident contact. The policy continued to state if medications come in (continued on next page)

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact with the care hands of the nurse, med tach, or with the cart, the medication should be disposed of per policy and new medications obtained. Further review revealed staff are to apply gloves as necessary (e.g.) eye drops, enteral, injections, etc.).This deficiency represents non-compliance investigated under Complaint Number 2991045.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observations, staff interview and facility policy review, the facility failed to follow infection control procedures during medication administration. This affected two residents, (#62 and #79) of four residents reviewed for medication administration. The facility census was 79.Findings include:1. Review of the medical record for Resident #62 revealed an admission rate of 06/01/24 with medication diagnoses of bipolar disorder, depression with psychotic features, Diabetes Mellitus (DM), paranoid schizophrenia, and hypertension.Review of Resident #62's quarterly Minimum Data Set (MDS) assessment, dated 04/28/26, revealed Resident #62 was cognitively intact and required substantial/maximum staff assistance with toilet hygiene, was dependent upon staff for bathing, and was independent with bed mobility and transfers. Review of Resident #62's physician orders revealed orders dated 03/30/26 for Depakote (anticonvulsant) 25 mg one tablet by mouth daily, Losartan Potassium (used to treat high blood pressure) 100 mg one tablet by mouth daily, Potassium Chloride (electrolyte supplement) 20 milliequivalent (meq)n one tablet by mouth daily, Metformin (used to treat DM) 500 mg one tablet by mouth two times per day, and a multivitamin one tablet by mouth daily. Further review of physician orders revealed orders dated 04/08/26 for Claritin (antihistamine) 10 milligram (mg) one tablet by mouth daily and orders dated 05/16/26 for Ativan (antianxiety) 0.5 mg one tablet by mouth daily and Risperdal (antipsychotic medication)0.5 mg one tablet every morning. Observation on 05/18/26 at 9:15 A.M. revealed Registered Nurse (RN) #210 prepared medications for Resident #62 by placing Ativan, Depakote, Metformin, Potassium Chloride, multivitamin tablets into a medication cup. RN #210 was observed to place Claritin and Losartan tablets into her bare hands prior to placing them into the medication cup. The observation revealed RN #210 could not administer Risperdal as ordered because the medication was not available from pharmacy. RN #210 gave the medications to Resident #62 and observed the resident consuming the medications. Interview on 05/18/26 at 9:29 A.M. with RN #210 confirmed she placed Resident #62's Claritin and Losartan tablets into her bare hands prior to placing the medications into the medication cup. 2. Review of the medical record for Resident #79 revealed an admission date of 04/14/26 with medication diagnoses of pulmonary hypertension, DM, heart failure, and peripheral vascular disease.Review of Resident #79's admission MDS assessment, dated 04/15/26, revealed Resident #79 was cognitively intact and required substantial/maximum staff assistance with bathing and toilet hygiene and partial/moderate staff assistance with bed mobility and transfers. Review of Resident #79's physician orders revealed an order dated 04/15/26 for Humalog Kwikpen subcutaneous solution pen injection (Insulin Lispro) (used to treat DM) 100 units per milliliter (ml) per sliding scale: if finger stick blood sugar 140-189 give one unit, if 190-239 give three units, if 240- 289 give five units, if 290-339 give seven units, if 340-389 give nine units, and if greater than 389 notify the physician, administer subcutaneously three times per day. Observation on 05/18/26 at 11:26 A.M. of RN #210 prepared Resident #79's Lispro insulin for administration. RN #210 was observed to withdraw one unit of Insulin Lispro from a vial and administered the insulin into Resident #79's left arm. The observation revealed RN #210 did not use hand hygiene or apply gloves prior to the administration of the insulin. Interview on 05/18/26 at 11:29 A.M. with RN #210 confirmed she had not performed hand hygiene or applied gloves prior to administering Resident #79's insulin. RN #210 also confirmed she used a vial of Lispro insulin for the administration to Resident #79 and not the kwikpen as ordered.Review of the facility policy titled, Medication Administration, revised 10/17/24 stated resident medications are to be administered in an accurate, safe, timely, and sanitary manner. The policy stated medications are to be administered in accordance with written orders of the attending physician. The policy stated staff are to perform hand hygiene prior to medication preparation for each medication pass and perform hand hygiene after direct resident contact. The policy continued to state if medications come in contact with the care hands of the nurse, med tech, or with the cart, the medication should be disposed of per policy and new medications obtained. Further review revealed staff are to apply (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves as necessary (e.g.) eye drops, enteral, injections, etc.).This deficiency was based on incidental findings discovered during the complaint investigation.