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	09/09/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to assess a resident for self-administration of medications prior to allowing the resident to keep medication at their bedside for one (Resident #79) of two residents reviewed for self-administration of medications. The facility census was 78.Findings included:An admission Record revealed the facility admitted Resident #79 on 12/12/2024. According to the admission Record, Resident #79 had a medical history that included diagnoses of nontraumatic intracranial hemorrhage (bleeding in the brain not caused by an external injury), chronic obstructive pulmonary disease (COPD), and anxiety disorder.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/21/2025, revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident required moderate assistance with all activities of daily living (ADLs).Resident #79's Care Plan Report revealed the last care plan review was completed on 07/23/2025. The Care Plan Report revealed no indication the resident was able to self-administer medication.Resident #79's Order Summary Report, listing active orders as of 09/02/2025, revealed no order for self-administration of medications or for medications to be left at the bedside. Resident #79's medical record revealed no documented evidence the resident had been assessed for self-administration of medications. An observation on 09/02/2025 at 1:51 PM revealed Resident #79 was in their room in bed with an inhaler at their bedside. An observation on 09/03/2025 at 9:00 AM revealed Resident #79 was in their room in bed with an inhaler in a chair at their bedside.An observation on 09/04/2025 at 9:00 AM revealed Resident #79 was in their room in bed with an inhaler at their bedside. An observation on 09/04/2025 at 11:12 AM revealed Resident #79 was in their room in bed with an albuterol inhaler in the chair next to their bed.During an interview on 09/04/2024 at 11:12 AM, Resident #79 stated that they liked to keep their inhaler handy in case they needed it. Resident #79 stated that staff saw their inhaler in their room every day when they entered the room. Resident #79 stated that no staff had ever questioned them about their inhaler. During a concurrent observation and interview on 09/04/2025 at 1:39 PM, Registered Nurse (RN) #2 stated that if a resident wanted to keep medications at their bedside, there was a facility process, but she was not sure what the process consisted of and would have to refer to her unit manager for clarification. RN #2 then accompanied Resident #79 to their room and identified the inhaler in the chair at their bedside as albuterol and stated that it should not be at the resident's bedside. RN #2 explained to the resident that she would be removing the medication. Resident #79 became agitated and stated, It's always been here. The medication was removed with the consent of the resident. During an interview on 09/04/2025 at 2:45 PM, the Director of Nursing (DON) stated there were currently no residents that could self-administer medications. The DON stated that the policy for self-administration of medications indicated that for a resident to have medications at their bedside and to self-administer, there needed to be an assessment conducted by the facility and a physician's order. She stated that her expectation was that any medication found at a resident's bedside would be removed, a phone call would be made to the physician, and the physician and interdisciplinary team (IDT) would decide, following an assessment, if a resident was appropriate to self-administer medications.A facility policy titled, Medication Administration, revised 10/17/2023, indicated, Self-Administration - residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with the guideline for self-administration of medication. A self-administration evaluation will be completed prior to the resident starting the self-administering process. Self-administration of medication will be reflected in the resident care plan along with any special considerations.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, facility document review, and interview, the facility failed to protect a resident's right to be free from misappropriation of property for one (Resident #101) of one resident reviewed for abuse. The facility census was 78. Findings included:An admission Record revealed the facility admitted Resident #101 on 05/24/2025. According to the admission Record, the resident had a medical history that included a diagnosis of spinal stenosis, site unspecified. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/31/2025, revealed Resident #101 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Resident #101's Inventory of Personal Effects, dated 05/24/2025 indicated, A sum of $669 found in wallet.A facility document titled, Incident and Accident Investigation Form, signed by the Administrator (ADM) and dated 06/12/2025, indicated that the facility admitted Resident #101 on 05/24/2025, and upon admission was noted to have $669.00 in their wallet. Per the Incident and Accident Investigation Form, the charge nurse (Licensed Practical Nurse [LPN] #17) notified a unit manager (LPN #16), who directed the charge nurse to place the money in a narcotic drawer in a medication cart. The document indicated that when the charge nurse returned to the facility on [DATE], the money was not in the narcotic drawer. Per the Incident and Accident Investigation Form, the unit manager indicated they had not moved the money. The document indicated that on 06/06/2025, Resident #101 asked for their money and at that time the ADM and Director of Nursing (DON) were notified. The Incident and Accident Investigation Form revealed, Investigation indicates that the money was in possession of the facility and was not stored correctly or reported correctly to the Administrator or DON. The money was stored in a medication cart narcotic drawer which is double locked. No staff members state knowledge of the money's location after it was placed in the narcotic drawer on 5.24.25. During a telephone interview on 09/05/2025 at 3:50 PM, Certified Nurse Aide (CNA) #6 stated he remembered completing inventory with Resident #101, who was admitted on the weekend. He stated that they counted Resident #101's money together. CNA #6 stated that he recalled the amount was over $600. He stated he gave the money to a nurse, and she put it in her medication cart. CNA #6 stated he never saw the resident's money again after that.During a telephone interview on 09/05/2025 at 10:55 AM, LPN #16 stated that LPN #17 called her and informed her that she (LPN #17) had placed Resident #101's wallet that had money in it into the locked medication cart. LPN #16 stated that a few days later, she received a text from LPN #17 asking if she had taken the money out of the narcotic drawer. LPN #16 stated she told LPN #17 she had not removed the money. LPN #16 stated she did not take Resident #101's money. Attempts to interview LPN #17 via telephone were made on 09/05/2025 at 12:01 PM and on 09/06/2025 at 8:33 AM. Voice messages were left but no return call was received.During a telephone interview on 09/05/2025 at 12:11 PM, LPN #7 stated Resident #101 asked for their wallet, and when she looked for the wallet, she was unable to find it. LPN #7 stated that another nurse placed Resident #101's wallet in the medication cart. During a phone interview on 09/05/2025 at 11:30 AM, LPN #8 stated she could not remember which day it was, but Resident #101 asked for their wallet, and she could not find the wallet in her assigned medication cart or in the resident's room. She stated she never saw Resident #101's wallet.During an interview on 09/05/2025 at 1:23 PM, the ADM stated that when she came to the facility after the prior ADM left without notice, she was made aware of the situation with Resident #101 and the missing money. The ADM said she started an investigation on 06/12/2025. She stated staff were aware the money was missing on 05/30/2025 (when LPN #17 returned to work). She stated that on around 06/06/2025, Resident #101 asked for their money, and no one was able to locate the money. The ADM stated the resident's money was never located. She stated that throughout her investigation, she was unable to determine what happened to Resident #101's money or who took the money. She stated they interviewed staff after pulling the schedule to see who was assigned to the medication cart where the money was placed. She stated they searched the cart, contacted the police, interviewed other residents and family members, provided education on abuse prohibition, then replaced the money. Per the ADM, they did not substantiate the allegation of misappropriation of property. A facility policy titled, Abuse Prohibition Policy, effective 10/14/2022, indicated, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. This deficiency represents non-compliance investigated under Incident 1346629.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, facility document review, and interview, the facility failed to report an allegation of misappropriation of property within 24 hours, which affected one (Resident #101) of one resident reviewed for abuse. The facility census was 78. Findings included:An admission Record revealed the facility admitted Resident #101 on 05/24/2025. According to the admission Record, the resident had a medical history that included a diagnosis of spinal stenosis, site unspecified. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/31/2025, revealed Resident #101 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. A facility document titled, Incident and Accident Investigation Form, signed by the Administrator (ADM) and dated 06/12/2025, indicated that the facility admitted Resident #101 on 05/24/2025, and upon admission was noted to have $669.00 in their wallet. Per the Incident and Accident Investigation Form, the charge nurse (Licensed Practical Nurse [LPN] #17) notified a unit manager (LPN #16), who directed the charge nurse to place the money in a narcotic drawer in a medication cart. The document indicated that when the charge nurse returned to the facility on [DATE], the money was not in the narcotic drawer. Per the Incident and Accident Investigation Form, the unit manager indicated they had not moved the money. The document indicated that on 06/06/2025, Resident #101 asked for their money and at that time the ADM and the DON were notified. The Incident and Accident Investigation Form revealed, Investigation indicates that the money was in possession of the facility and was not stored correctly or reported correctly to the Administrator or DON. The money was stored in a medication cart narcotic drawer which is double locked. No staff members state knowledge of the money's location after it was placed in the narcotic drawer on 5.24. 25.The facility's investigation documents included an Ohio Department of Health Self Reported Incident Form, #261532, dated 06/12/2025, that indicated the facility reported to the state survey agency that Resident #101 had a wallet that contained $669.00 upon admission and the money had been placed in the narcotic drawer of the medication cart, and was later unable to be located. An email correspondence from the state survey agency to the ADM, dated 06/12/2025 at 10:49 AM, indicated that the state survey agency had received the facility's Self Reported Incident Form, #261532, which was 13 days after staff became aware Resident #101's money was missing. During an interview on 09/05/2025 at 1:19 PM, DON stated she had no knowledge of the allegation. She stated that she had only been the DON for a week and a half prior to the survey. She stated she expected any allegation of abuse to be reported immediately, then the ADM should report it within two or 24 hours.During an interview on 09/05/2025 at 1:23 PM, the ADM stated she started an investigation on 06/12/2025. She stated staff were aware the money was missing on 05/30/2025 but, to her knowledge, it was not reported to the state survey agency at that time. She stated that on around 06/06/2025, Resident #101 asked for their money, and no one was able to locate the resident's money. She stated it was not reported to the state survey agency at that time either. A facility policy titled, Abuse Prohibition Policy, effective 10/14/2022, indicated, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. The policy revealed, G. Reporting abuse and facility Response to the allegation, included 1. The staff will report any allegations or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown source to the Administrator and DON [Director of Nursing] immediately, and 2. The Administrator or designee will notify the guest's/resident's representative. Also, any State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours).This deficiency represents non-compliance investigated under Incident 1346629.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, facility document review, and interview, the facility failed to thoroughly investigate an allegation of misappropriation of property, which affected one (Resident #101) of one resident reviewed for abuse. The facility census was 78. Findings included:An admission Record revealed the facility admitted Resident #101 on 05/24/2025. According to the admission Record, the resident had a medical history that included a diagnosis of spinal stenosis, site unspecified. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/31/2025, revealed Resident #101 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment.A facility document titled, Incident and Accident Investigation Form, signed by the Administrator (ADM) and dated 06/12/2025, indicated that the facility admitted Resident #101 on 05/24/2025, and upon admission was noted to have $669.00 in their wallet. Per the Incident and Accident Investigation Form, the charge nurse (Licensed Practical Nurse [LPN] #17) notified a unit manager (LPN #16), who directed the charge nurse to place the money in a narcotic drawer in a medication cart. The document indicated that when the charge nurse returned to the facility on [DATE], the money was not in the narcotic drawer. Per the Incident and Accident Investigation Form, the unit manager indicated they had not moved the money. The document indicated that on 06/06/2025, Resident #101 asked for their money and at that time the ADM and the Director of Nursing (DON) were notified. The Incident and Accident Investigation Form revealed, Investigation indicates that the money was in possession of the facility and was not stored correctly or reported correctly to the Administrator or DON. The money was stored in a medication cart narcotic drawer which is double locked. No staff members state knowledge of the money's location after it was placed in the narcotic drawer on 5.24.25. Daily Staffing Sheet documents for the timeframe from 05/24/2025 (the day the money was placed in the medication cart) through 05/30/2025 (the day LPN #17 discovered the money was missing), indicated that staff assigned to the hall where Resident #101 resided, and who would have been assigned to the medication cart where the money was placed, included LPN #18, LPN #19, Registered Nurse (RN) #20, LPN #21, LPN #15, and LPN #8. The facility's investigation documents revealed no evidence that LPN #18, LPN #19, RN #20, LPN #21, or LPN #15 were interviewed regarding the resident's missing money. The documents indicated that LPN #8 was interviewed, but there was no evidence of a statement from the nurse or the details of the interview.During an interview on 09/05/2025 at 1:19 PM, the DON stated she expected investigations to be thorough. She stated she expected any staff who were witnesses or may have knowledge of the allegation to be interviewed. During an interview on 09/05/2025 at 1:23 PM, the ADM stated they interviewed staff after reviewing the schedule to see who was assigned to the medication cart where Resident #101's money was placed. She stated that they searched the cart, contacted the police, interviewed other residents and family members, provided education on abuse prohibition, and replaced the money. She stated they did not have statements or interviews for six of the seven nurses identified as having access to the medication cart. In regard to the investigation being thorough, the ADM acknowledged that it was not. A facility policy titled, Abuse Prohibition Policy, effective 10/14/2022, indicated, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. The policy revealed, E. Investigation included 7. The investigation may consist (as appropriate) of, which included a. A review of the completed Incident Report; b. An interview with the person(s) reporting the incident; c. Interviews with any witnesses to the incident; d. An interview with the guest/resident, if possible; e. A review of the guest's/resident's medical record; and f. An interview with staff members having contact with the guest/resident during the period/shift of the alleged incident. This deficiency represents non-compliance investigated under Incident 1346629.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, and interview, the facility failed to develop and implement comprehensive person-centered care plans for three (Residents #21, #76, and #83) of three residents reviewed for smoking. Specifically, the facility failed to ensure the care plans accurately reflected the level of care required for the residents who smoked. The facility census was 78.Findings included:1. An admission Record indicated the facility admitted Resident #21 on 03/13/2023 and readmitted the resident on 06/17/2025. According to the admission Record, Resident #21 had a medical history that included a diagnosis of acute kidney failure, unspecified. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/24/2025, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Further review of the MDS revealed the resident used tobacco. Resident #21's Care Plan Report included a need statement initiated 07/11/2025, that indicated Resident #21 used smoking products and had been assessed as safe to smoke with supervision. Interventions initiated 07/11/2025 directed staff to assess the resident's ability to smoke safety per the facility policy, and educate the resident that smoking was only permitted under supervision of a staff member in the facility's designated smoking area during the facility's designated smoking times.Resident #21's Smoking Evaluation records, dated 06/23/2023, 07/31/2023, and 09/03/2025, revealed Resident #21 was a Safe smoker - Resident/Guest may opt to smoke independently. During an interview on 09/04/2025 at 11:47 AM, MDS Nurse #12 stated that when the nursing staff completed the admission comprehensive assessments, they used the information to develop the care plan. MDS Nurse #12 stated that when the quarterly assessments were completed, nursing updated the care plans as well. MDS Nurse #12 stated nursing staff participated in the clinical nurses' meeting, and they updated care plans as needed. She stated Resident #21's care plan was not accurate regarding the resident's smoking status. She stated Resident #21 was a safe, independent smoker who did not require supervision. During an interview on 09/04/2025 at 11:36 AM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated the information on Resident #21's care plan should come from Resident #21's comprehensive care plan assessment. The ADON/IP stated the smoking information on the care plan came from Resident #21's admission smoking evaluation. She stated the information from Resident #21's smoking evaluation was not accurately reflected on the care plan. She stated that Resident #21 was assessed as a safe smoker who could smoke independently; however, the care plan was inaccurate and reflected the resident needed supervision while smoking. During an interview on 09/04/2025 at 12:12 PM, the Director of Nursing (DON) stated the smoking care plan for Residents #21 was not accurate and did not accurately reflect their smoking assessment. The DON stated she could not speak to why the care plan was not accurate. 2. An admission Record indicated the facility admitted Resident #76 on 07/20/2025 and readmitted the resident on 08/09/2025. According to the admission Record, Resident #76 had a medical history that included a diagnosis of chronic diastolic (congestive) heart failure. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/27/2025, revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #76's Care Plan Report included a need statement initiated 07/20/2025 and revised 08/05/2025, that indicated Resident #21 wished to use smoking products and had been assessed as safe to smoke with supervision. Interventions initiated 07/20/2025 directed staff to assess the resident's ability to smoke safely per the facility policy and maintain all smoking paraphernalia for all unsafe and safe smokers.Resident #76's Smoking Evaluation, dated 07/21/2025, revealed Resident #76 was an Unsafe smoker - Resident is to be supervised. During an interview on 09/04/2025 at 11:20 AM, Licensed Practical Nurse (LPN) #15 stated the information on Resident #76's care plan came from the resident's smoking assessment. LPN #15 stated she did not know why the care plan failed to reflect the change in Resident #76's smoking status to unsafe. She stated MDS staff were the ones who made sure care plans were updated and accurate. During an interview on 09/04/2025 at 11:47 AM, MDS Nurse #12 stated Resident #76's care plan was not accurate. She stated Resident #76 was deemed an unsafe smoker and was no longer allowed to smoke. The MDS Coordinator stated she had never heard of supervised smoking at the facility. During an interview on 09/04/2025 at 12:12 PM, the Director of Nursing (DON) stated the care plan for Resident #76 was not accurate. The DON stated she could not speak to why Resident #76 care plan was not accurate. 3. An admission Record indicated the facility admitted Resident #83 on 08/08/2019 and readmitted the resident on 10/24/2024. According to the admission Record, the resident had

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to update a care plan to consistently reflect a diet change from nothing by mouth (NPO) to a pureed diet for one (Resident #2) of 19 residents reviewed for care plans. The facility census was 78. Findings included:An admission Record revealed the facility admitted Resident #2 on 06/03/2025. According to the admission Record, the resident had a medical history that included diagnoses of unspecified protein-calorie malnutrition and dysphagia (difficulty swallowing).An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/10/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident was not assessed for eating, had a feeding tube, and received greater than 51% of their total calories through parental or tube feeding. According to the MDS, the resident had a feeding tube and received a therapeutic diet while a resident of the facility.A significant change in status MDS, with an ARD of 08/20/2025, revealed Resident #2 had a BIMS score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required supervision or touching assistance for eating, received a mechanically altered diet, had a feeding tube, and received greater than 51% of their total calories through parental or tube feeding. Resident #2's Care Plan Report included the following need statements:- a need statement, initiated on 06/03/2025 and revised on 06/05/2025, that indicated the resident was at risk for nutritional decline related to severe protein-calorie malnutrition, NPO diet with tube feeding regimen, and multiple skin impairments. Despite the need statement indicating the resident was NPO, an intervention dated 06/06/2025 directed staff to provide feeding/dining assistance as needed;- a need statement, initiated on 06/03/2025 and revised on 06/05/2025, that indicated the resident was unable to tolerate nutritionally adequate food and/or fluids by mouth, requiring the use of a feeding tube related to NPO diet orders, history of inadequate oral intake as evidence by underweight body mass index (BMI), severe fat and muscle loss, low body weight, and abnormal laboratory values; - a need statement, initiated on 06/16/2025 and revised on 08/07/2025, that indicated the resident had a functional ability deficit, was unable to eat by mouth, and received nutrition via feeding tube. Interventions dated 06/16/2025 that directed staff on the level of assistance the resident required for various activities of daily living (ADLs) indicated, {Eating = NPO receives nutrition Via G-tube [gastrostomy tube]} and Resident is not able to complete: Eating. However, an additional intervention dated 08/06/2025 directed staff to get the resident up daily for meals; and- a need statement, initiated on 06/05/2025, that indicated the resident had nutritional and hydration risk. An intervention, revised on 08/22/2025, directed staff to provide diet as ordered, Regular/Pureed/Honey Thick Liquids.Resident #2's Order Summary Report, including all active, completed, and discontinued orders through 09/03/2025, contained an order, dated 08/22/2025, to discontinue mechanical soft snacks between meals and continue pureed diet and honey thickened liquids.During an observation on 09/03/2025 at 12:15 PM, Resident #2 was in the activity room, with staff present, eating a pureed diet with honey thickened liquids.During an interview on 09/05/2025 at 3:40 PM, MDS Nurse #12 stated she was in charge of care plans. She stated care plans were updated every quarter and as changes were identified during clinical meetings. MDS Nurse #12 also stated nurses were to update the care plan in real time, and staff should have discontinued Resident #2's care plans that reflected NPO status and started a new nutritional care plan.During an interview on 09/05/2025 at 4:01 PM, the Director of Nursing (DON) stated any nurse could update care plans, but she and MDS Nurse #12 were ultimately responsible for ensuring the accuracy of care plans. The DON stated that care plans that were no longer an issue should be deleted, and dietary care plans should be revised during the weekly risk meetings. The DON stated she expected care plans to be reviewed on a regular basis and updated as needed.During an interview on 09/05/2025 at 4:27 PM, the Administrator stated nursing staff and facility leadership were responsible for the accuracy of care plans. The Administrator stated the expectation was that care plans accurately represent each resident.A facility policy titled, Care Planning, effective on 03/03/2025, revealed the section titled, Procedure specified, 7. The care plan must be specific, resident centered, individualized and unique to each resident and may include: involve and communicate needs of the resident with direct care staff. The policy further revealed, 9. The care plan and resident kardex will be updated on admission, quarterly, annually and with significant changes. This includes adding new focuses, goals and interventions and resolving ones that are no longer applicable as needed.

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Laurels of West Carrollton The	115 Elmwood Circle West Carrollton, OH 45449

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to provide nail care for 1 (Resident #7) of 2 sampled residents reviewed for activities of daily living (ADL) care. Findings included:A facility policy titled, Routine Resident Care, revised 03/12/2025, indicated, 3. Daily personal hygiene minimally includes assisting or encouraging residents with washing their face and hands, shaving, nail care, combing their hair each morning, and brushing their teeth and/or providing denture care. A facility policy titled, Personal Hygiene, revised 03/05/2025, indicated, VI. Nail care: A. Nails should be kept neatly trimmed. An admission Record revealed the facility admitted Resident #7 on 06/27/2024. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, type two diabetes mellitus, and chronic kidney disease. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/15/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had functional limitation in range of motion on one side of both their upper and lower extremities and required substantial/maximal assistance from staff with personal hygiene. Resident #7's Care Plan Report included a need area, revised on 07/23/2024, that indicated the resident required assistance with self-care/mobility related to hemiparesis and hemiplegia. Interventions directed staff to keep fingernails trimmed and clean. During an observation on 09/02/2025 at 12:00 PM, Resident #7 was observed with long fingernails that extended past the end of their fingertips on all five fingers of their left hemiparetic hand. During an interview on 09/02/2025 at 12:02 PM, Resident #7 stated they wanted their fingernails on their left hand trimmed, but the nurse had to do it since they were diabetic. During an interview on 09/04/2025 at 11:44 AM, Resident #7 stated they had a bed bath the prior afternoon provided by staff, and no one trimmed their fingernails. Fingernails were observed on all five fingers of their left hemiparetic hand that extended past their fingertips. During an interview on 09/04/2025 at 11:59 AM, Registered Nurse (RN) #2 stated the certified nurse aides cleaned resident fingernails during ADL care, but the nurse must complete all resident nail trims. RN #2 stated Resident #7's fingernails on the left hand needed to be trimmed to prevent skin breakdown and to prevent the resident from scratching themself. RN #2 stated the expectation was to keep all fingernails trimmed to or below the tip of the finger or to the resident's preference. During an interview on 09/05/2025 at 8:49 AM, the Director of Nursing (DON) stated nail care, including cleaning and trimming of fingernails, was expected to be completed at a minimum of two times a week and as needed. The DON stated the nurse must complete all nail trims for diabetic residents. The DON stated Resident #7's fingernails should have been trimmed and should not extend past their fingertips. During an interview on 09/05/2025 at 8:51 AM, the Administrator (ADM) stated their expectation was for all residents' fingernails to be kept clean and trimmed to the resident's preference. The ADM stated Resident #7's nails should be kept clean, trimmed, and should not extend past their fingertips.

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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 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, observation, and interview, the facility failed to ensure the residents' environment remained free of accidental hazards, which affected one (Resident #65) of six residents reviewed for accidents. Specifically, Resident #65 had medications in their room, and they had not been assessed as safe to self-administer medication. The facility census was 78.Findings included:An admission Record indicated the facility admitted Resident #65 on 05/24/2025. According to the admission Record, the resident had a medical history that included diagnoses of acute and chronic respiratory failure with hypoxia, pneumonia, and chronic obstructive pulmonary disease (COPD).A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/2025, indicated Resident #65 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had no impairment to their range of motion in their bilateral upper and lower extremities. Resident #65's Care Plan Report last reviewed 08/25/2025, revealed no evidence that the resident could store or self-administer their medication. Resident #65's Order Summary Report, with active orders as of 09/04/2025, contained an order, dated 06/19/2025, for fluticasone propionate nasal suspension (an inhaled corticosteroid) 50 mcg/ACT (micrograms per actuation), with instructions to administer two sprays in each nostril twice a day for allergies. The Order Summary Report revealed no order for the fluticasone propionate nasal suspension to be self-administered by Resident #65. The Order Summary Report revealed no orders for eye drops, triple antibiotic ointment, or saline nasal spray.An observation on 09/02/2025 at 12:43 PM revealed items on Resident #65's bedside table within reach included a bottle of fluticasone nasal spray, a tube of triple antibiotic ointment, a bottle of saline nasal spray, and a bottle of eye drops. During an interview at the time of the observation, Resident #65 stated they had ordered the fluticasone nasal spray, saline nasal spray, triple antibiotic ointment, and eye drops and had them delivered to the facility a couple of weeks prior. The resident stated they wanted the items within close reach to administer them when needed. The resident stated they were unaware if staff knew the items were in their possession but pointed to their bedside table and stated the items had been sitting on the table for a couple of weeks. During the observation, Resident #65 picked up the fluticasone nasal spray from the bedside table independently, looked at the label, and stated the spray was for their allergies, then placed the bottle back on the bedside table. During an observation on 09/04/2025 at 11:01 AM, a bottle of fluticasone nasal spray, a bottle of eye drops, and a tube of triple antibiotic ointment were observed on Resident #65's bedside table. During an interview on 09/04/2025 at 1:22 PM, Certified Nurse Aide (CNA) #5 stated medications were not to be left at a resident's bedside. CNA #5 stated they were to report to a nurse if any medications were left in a resident's room. During an interview on 09/05/2025 at 8:23 AM, Licensed Practical Nurse (LPN) #1 stated that over the counter (OTC) or prescription medications were not allowed to be left in a resident's room. LPN #1 stated any medications found in a resident's room would be removed immediately and secured in a nurse's medication cart. LPN #1 verified Resident #65 had saline nasal spray, fluticasone nasal spray, eye drops, and triple antibiotic ointment on their bedside table, and stated they needed to be removed as the items were not allowed to be kept in the resident's room.During an interview on 09/04/2025 at 11:25 AM, Registered Nurse (RN) #2 stated that residents were not allowed to have OTC or prescription medications at their bedside or in their room, including nasal spray, triple antibiotic ointment, or allergy medicine. RN #2 stated there were no residents at the facility that self-administered their medications. RN #2 stated any medication found in a resident's room was removed immediately. RN #2 stated Resident #65 would be educated on why medications could not be left in their room without a doctor's order and an assessment for self-administration.During an interview on 09/05/2025 at 8:39 AM, the Director of Nursing (DON) stated she expected all resident prescription and OTC medications to be locked in a medication cart and not left in residents' rooms. The DON observed and confirmed Resident #65 had fluticasone nasal spray, saline nasal spray, eye drops, and triple antibiotic ointment on the resident's bedside table. The DON removed all items from the resident's room and educated the resident that medications could not be in the resident's room. During an interview on 09/05/2025 at 8:55 AM, the Administrator (ADM) stated she expected medications to not be in a resident's room. The ADM stated she expected staff to remove any medications found in a resident's room, the doctor, DON, and ADM aware if medications were located, and provide education to the resident.A facility policy titled, Medication Administration, revised 10/17/2023, indicated Self-Administration - residents are allowed to self-administer medication when specifically authorized by the attending physician

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility document review, the facility failed to ensure urinary catheter tubing was secured to prevent urethra (tube that transports urine from the body) trauma for one (Resident #49) of one resident reviewed for indwelling urinary catheters. The facility census was 78. Findings included:An admission Record revealed the facility admitted Resident #49 on 01/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of benign prostatic hyperplasia without lower urinary tract symptoms, obstructive and reflux uropathy, and retention of urine. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/02/2025, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated severe cognitive impairment. The MDS indicated the resident was dependent on staff for toileting hygiene, had an indwelling catheter, and was always incontinent of bowel. Resident #49's Care Plan Report, included a need statement initiated on 01/23/2025, that indicated the resident was at risk for urinary tract infection and catheter-related trauma and had a urinary catheter related to obstructive and reflux uropathy and benign prostate hyperplasia (BPH). Interventions directed staff to ensure the urinary catheter tubing was secured and to observe and document for pain or discomfort due to catheter (initiated on 02/03/2025). Resident #49's Order Summary Report indicated the resident had an order dated 08/27/2025 for Foley catheter care every shift for maintenance. During a concurrent interview and observation of urinary catheter care for Resident #49 on 09/05/2025 at 1:28 PM, it was noted the resident's urinary catheter tubing was not secured to prevent trauma to the urethra. The observation revealed Certified Nursing Aide (CNA) #1 provided catheter care and CNA #2 assisted. Further observation revealed CNA #2 removed the resident's brief and tucked the brief between the resident's leg, which caused tugging on the tubing. CNA #1 then cleaned the catheter tubing from the point of the insertion, then down and around the tubing, holding the tubing just shy of the insertion site, tugging on the tubing occurred during the cleaning. After CNA #1 completed the catheter care, CNA #2 pulled the resident's brief back up between the resident's legs again, causing tugging on the catheter tubing. After catheter care was completed, CNA #1 said the resident needed a catheter anchor placed on either of their thighs to ensure the catheter tubing was secured to prevent tugging during catheter and resident care/treatment. She stated Resident #49 did not have an anchor and the resident had not had one since being readmitted from the hospital a while ago.During an interview on 09/05/2025 at 1:32 PM, Registered Nurse (RN) #2 said Resident #49 returned from the hospital on [DATE]. She said she did not know if Resident #49 had an anchor securing the urinary catheter tubing, but the CNA who cared for the resident would know. She was then informed that CNA #1, who just completed Resident #49's catheter care, said that the resident had not had an anchor since they returned from the hospital. During an interview on 09/06/2025 at 2:05 PM, the Director of Nursing (DON) said she expected every resident with an indwelling Foley catheter to have an anchor attached to one of their thighs to prevent possible trauma to the urethra. During an interview on 09/06/2025 at 2:19 PM, the Administrator said she would contact the physician to get an order for an anchor if it was needed, but she referred all nursing issues to the DON since she was not a nurse.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on facility policy review, record review, and interview, the facility failed to prevent a significant medication error for one (Resident #6) of five residents reviewed for unnecessary medications. Specifically, Resident #6 received insulin glargine when the resident's blood sugar was less than 140 and should not have been given, per their physician orders. The facility census was 78.Findings included:An admission Record revealed the facility admitted Resident #6 on 01/13/2024. According to the admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus without complications. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/23/2025, revealed Resident #6 had a Brief Interview of Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident received four insulin injections during the seven-day look-back period. Resident #6's Care Plan Report included a need statement initiated 01/28/2024, that indicated the resident was at risk for fluctuation in blood sugar levels related to diabetes mellitus. Interventions directed staff to administer medication as ordered and to observe for ineffectiveness, side effects, and to report abnormal findings to the physician (initiated 01/28/2024). Resident #6's September 2025 Order Summary Report, with active orders as of 09/06/2025, contained an order, dated 05/03/2024, for insulin glargine pen-injector 300 unit/ml, inject 5 units subcutaneously once a day, with directions to not administer the injection if the resident's blood sugar was under 140. Resident #6's August 2025 Medication Administration Record [MAR] revealed staff documented administering insulin glargine on 08/12/2025, when the resident's blood sugar was documented as 118; and on 08/13/2025, when the resident's blood sugar was documented as 126.During an interview on 09/06/2025 at 2:39 PM, the Director of Nursing (DON) stated she expected the nurses to follow physician orders regarding administering insulin according to residents' blood sugar results. She also stated that she expected the nurses to get clarification from the physician if they had any doubts, and only the physician could order for a medication to not be held according to the parameters. During an interview on 09/06/2025 at 2:41 PM, the Administrator (ADM) stated she expected the staff to follow physician orders.A facility policy titled, Medication Administration, revised 10/17/2023, indicated, Authorized Personnel - Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. The policy revealed, Physician Orders - Medications are administered in accordance with written orders of the attending physician.

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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. (continued on next page)

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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	Based on facility policy review, record review, observation, and interview, the facility failed to implement Enhanced Barrier Precautions (EBP) for one (Resident #49) of 35 residents on EBP. The facility census was 78. Findings included:An admission Record revealed the facility admitted Resident #49 on 01/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of benign prostatic hyperplasia without lower urinary tract symptoms, obstructive and reflux uropathy, and retention of urine. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/02/2025, revealed Resident #49 had a Brief Interview of Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for toileting hygiene, had an indwelling catheter, and was always incontinent of bowel. The MDS indicated the resident had one Stage 3 and one Stage 4 unhealed pressure ulcers.Resident #49's Care Plan Report included a need statement initiated 01/23/2025 and revised 05/15/2025, that indicated the resident had an indwelling catheter. Interventions directed staff to follow EBP (initiated 05/15/2025). The Care Plan Report included a need statement initiated 05/09/2025 and revised 08/18/2025, that indicated the resident had an actual impaired skin integrity related to pressure injuries. Interventions directed staff to follow EBP (initiated 05/09/2025).Resident #49's Order Summary Report, with active orders of 09/06/2025, contained orders to provide wound treatments to the resident's left medial foot (order date 08/28/2025), right medial ankle (order date 09/04/2025), right foot (order date 08/28/2025), and coccyx (order date 08/14/2025). The Order Summary Report also contained an order dated 08/27/2025 for staff to provide catheter care. The Order Summary Report also contained an order dated 09/05/2025, that indicated the resident was to be on EBP related to a history of methicillin-resistant staphylococcus aureus (MRSA), and due to having an indwelling catheter. During an observation on 09/05/2025 at 10:13 AM, Licensed Practical Nurse (LPN) #13 and LPN #14 provided wound care treatment to Resident #49's right heel and right medial ankle and foot. Both staff entered the resident's room with gloved hands, but no gowns were put on at any time during the wound treatments. Personal protective equipment (PPE) supplies were observed in a plastic two-drawer cart directly outside the resident's room. During the wound treatment, LPN #13's and LPN #14's scrub tops touched the resident's bed mattress and covers while turning the resident and when LPN #13 was providing wound vacuum-assisted closure (VAC) change to the resident's right heel. During an interview on 09/05/2025 at 10:40 AM, outside of Resident #49's room, LPN #14 stated EBP should be followed when providing wound care and that gloves and gown should be used. LPN #14 stated she had been trained to follow EBP and should have followed the EBP when providing wound care to Resident #49 but did not think about it at the time. She stated it was important to prevent the spread of infection since Resident #49 had an active wound infection. During an interview on 09/05/2025 at 10:42 AM with LPN #13 and the Assistant Director of Nursing (ADON)/Infection Preventionist (IP), LPN #13 stated Resident #49 was no longer on contact isolation since they no longer had a wound infection and they had completed their antibiotics. LPN #13 stated she did not think the resident should be on any type of infection control precautions since they no longer had a wound infection. The ADON/IP stated Resident #49 should have been on EBP since the resident had open wounds and a urinary catheter. The ADON/IP stated both nurses should have worn gowns and gloves while providing the wound treatments. During an interview on 09/06/2025 at 2:09 PM, the Director of Nursing (DON) stated her expectation was for staff to follow EBP for residents with open wounds. During an interview on 09/06/2025 at 2:22 PM, the Administrator stated that she expected staff to follow the EBP policy and signage on the door. A facility policy titled, Enhanced Barrier Precautions (EBP), revised 03/05/2025, indicated, It is the intent of this facility to use Enhanced Barrier Precautions (EBP) in addition to Standard Precautions for preventing the transmission of CDC [Centers for Disease Control and Prevention] targeted multidrug-resistant organisms (MDROs). Enhanced Barrier Precautions are indicated for residents with any of the following: 1) infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO and should remain in place for the duration of a resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that place them at higher risk. The policy continued, under the section, Gloves, Gowns and Hand Hygiene, A. Health care personnel caring for residents on Enhanced Precautions should wear gloves and gowns during high-contact resident care. Examples of high contact resident care activities requiring gown and glove use included, Wound care;

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, and interview, the facility failed to implement their smoking policy, which affected three (Residents #21, #76, and #83) of three residents reviewed for smoking. Specifically, smoking assessments were not completed fully or timely according to the policy. The facility census was 78.Findings included:1. An admission Record indicated the facility admitted Resident #21 on 03/13/2023 and readmitted the resident on 06/17/2025. According to the admission Record, Resident #21 had a medical history that included a diagnosis of acute kidney failure, unspecified. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/24/2025, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Further review of the MDS revealed the resident used tobacco. Resident #21's Care Plan Report included a need statement initiated 07/11/2025, that indicated Resident #21 used smoking products and had been assessed as safe to smoke with supervision. Interventions initiated 07/11/2025 directed staff to assess the resident's ability to smoke safety per the facility policy, and educate the resident that smoking was only permitted under supervision of a staff member in the facility's designated smoking area during the facility's designated smoking times.Resident #21's medical record revealed Smoking Evaluation records dated 06/23/2023, 07/31/2023, and 09/03/2025. The record revealed no evidence of a Smoking Evaluation being completed when the facility readmitted the resident on 06/17/2025.During an interview on 09/04/2025 at 11:47 AM, MDS Nurse #12 stated that a smoking evaluation for Resident #21 was completed on 07/31/2023 and another one was completed on 09/03/2025. During an interview on 09/04/2025 at 11:36 AM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated Resident #21 should have had another smoking evaluation completed when the resident was re-admitted in June 2025. 2. An admission Record indicated the facility admitted Resident #76 on 07/20/2025 and readmitted the resident on 08/09/2025. According to the admission Record, Resident #76 had a medical history that included a diagnosis of chronic diastolic (congestive) heart failure. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/27/2025, revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #76's Care Plan Report included a need statement initiated 07/20/2025 and revised 08/05/2025, that indicated Resident #21 wished to use smoking products and had been assessed as safe to smoke with supervision. Interventions initiated 07/20/2025 directed staff to assess the resident's ability to smoke safely per the facility policy and maintain all smoking paraphernalia for all unsafe and safe smokers.Resident #76's medical record revealed Smoking Evaluation records dated 07/21/2025 and 09/03/2025. The record review revealed no evidence of a smoking evaluation completed after the facility readmitted the resident on 08/09/2025.3. An admission Record indicated the facility admitted Resident #83 on 08/08/2019 and readmitted the resident on 10/24/2024. According to the admission Record, the resident had a medical history that included a diagnosis of polyneuropathy, unspecified. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/03/2025, revealed Resident #83 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #83's Care Plan Report included a need statement initiated 10/25/2024 and revised 06/06/2025, that indicated Resident #83 wished to use smoking products and had been assessed as safe to smoke with supervision. Interventions initiated 10/25/2024 directed staff to assess the resident's ability to smoke safely per the facility policy, and to maintain all smoking paraphernalia for all unsafe and safe smokers.Resident #83's Smoking Evaluation records revealed an evaluation, dated 04/18/2025, that revealed the Summary of Evaluation, which provided indication regarding whether the resident was a safe smoker that could smoke independently or was an unsafe smoker that needed to be supervised, was blank, leaving the evaluation incomplete.During an interview on 09/04/2025 at 8:50 AM, the Director of Nursing (DON) stated her experience had been that staff completed a smoking assessment upon admission. She stated she had not read their current smoking policy to determine how often a resident should be reassessed. During an interview on 09/04/2025 at 9:02 AM, the Administrator (ADM) stated she had been the Administrator officially for a week and a half at that time. She stated residents were asked if they were smokers upon admission, and if they said yes, a smoking assessment was conducted. She stated she had not read their smoking policy completely. She stated she expected assessments to be accurate. A facility policy titled, Smoking Policy, effective 06/17/2025, indicated, Resident's [sic] may smoke under limited circumstances outlined in this policy but only in a designated