STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365627	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Huber Heights The	5440 Charlesgate Road Huber Heights, OH 45424

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 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** 39702 Based on medical record review, staff interview and review of the facility policy, the facility failed to ensure resident representatives were notified of significant changes in residents health status. This affected one (Resident #90) of three residents reviewed for change in health condition. The facility census was 84 residents. Findings include: Review of the medical record for Resident #90 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #90 returned to the facility on [DATE] and discharged to the hospital on 05/11/24 and did not return to the facility. Resident #90's diagnoses included gram negative sepsis, congestive heart failure, non-pressure chronic ulcer of part of left lower leg, and renal disease. Review of the Minimum Data Set (MDS) assessment for Resident #90 dated 04/29/24 revealed the resident had intact cognition and required extensive assistance from two staff members for completion of activities of daily living (ADLs). Review of the progress note for Resident #90 dated 04/29/24 timed at 4:51 P.M. revealed the resident had a large intact blister noted to the calf of the right leg. Staff notified the Nurse Practitioner (NP) who gave orders for the wound care physician to see the resident. Interview on 06/26/24 at 10:10 A.M. with Licensed Practical Nurse (LPN) #157 confirmed the progress note for Resident #90 did not include documentation related to family notification of the blister to the resident's calf. Interview on 06/26/24 at 3:40 P.M. with Director of Nursing (DON) confirmed the facility had no record of notification to Resident #90's family of the resident's impaired skin integrity observed on 04/29/24. Review of the facility policy titled Change of Condition Notification dated 02/14/2024 revealed the facility should notify the resident's representative of changes in condition which included changes in the resident's physical, mental or psychosocial status that were a deterioration in health, mental, or psychosocial status. This deficiency represents noncompliance investigated under Complaint Number OH00154584.

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: 365627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Laurels of Huber Heights The		STREET ADDRESS, CITY, STATE, ZIP CODE 5440 Charlesgate Road Huber Heights, OH 45424	

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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** 36648 Based on medical record review, observation, resident interview, staff interview, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to notify the Ohio Department of Health (ODH) of an injury of unknown origin. This affected one (Resident #10) of three residents reviewed for abuse. The census was 84 residents. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including heart disease, dementia without behavioral disturbances, mood, anxiety and protein calorie malnutrition. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 03/23/24 revealed the resident was severely cognitively impaired and required the assistance of one staff member for bed mobility, dressing and personal hygiene and used a wheelchair for mobility. Review of the hospice visit report for Resident #10 dated 06/10/24 per Hospice Registered Nurse (RN)#600 revealed the resident had a bruise to the right cheek and the aide reported they were unaware of the origin of the bruise. Unit Manager (UM) #148 signed the report. Review of the incident report for Resident #10 dated 06/12/24 revealed the resident had a black eye. Further review of the report revealed State tested Nursing Assistant (STNA) #137 reported to Unit Manager (UM) # 148 she was giving incontinence care during the night on 6/11/24 and Resident #10 hit her glasses and possibly her head on the arm of a chair placed against the right side of the bed. Review of the investigation for the bruise to Resident #10 dated 6/12/24 revealed the resident could not recall how the incident occurred. State tested Nursing Assistant (STNA) #137 reported Resident #10 was agitated while she was giving P.M. care and while she was rolling Resident#10, the resident bumped her face on the chair next to the bed. Review of a timeline written by the Director of Nursing (DON) dated 6/12/24 revealed UM #148 interviewed all residents following Resident #10's bruise to determine if there were any abuse concerns. The document did not include assessment of cognitively impaired residents for bruising on their skin or injuries of unknown origin. Further review revealed STNA #137 was educated in abuse, dementia care, and customer service and was assigned to work on the day shift for two shifts for additional training. Review of the facility Self-Reported Incidents (SRIs) revealed there were no reports filed for Resident #10's injury of unknown origin. Interview on 06/20/24 at 10:36 A.M. with Resident # 55 confirmed she was concerned about Resident #10 having a black eye and she believed it was from a night shift aid giving care. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/20/24 at 10:40 A.M. of Resident #10 revealed the resident had bruising under her right eye and down her right side of cheek with dark color and yellowing. Resident #10 wore glasses which sat on her right cheek on the bruise extending from her right eye. (Resident #10 was non-interviewable.) Interviews with STNA #137 were attempted by telephone on 06/20/24 at 2:30 P. M. and on 06/24/24 at 3:15 P.M. but were unsuccessful. Interview on 06/27/24 at 9:18 A. M. with Hospice RN #600 confirmed she visited Resident #10 on 06/10/24 and identified a bruise on the resident's right cheek. RN #600 further confirmed she asked an STNA how the bruise occurred, but they didn't know. RN #600 confirmed the resident was unable to explain how she was bruised. RN #600 confirmed she reported the bruising to UM #148 and had the facility nurse sign the note dated 06/10/24 which noted the bruising. Interview on 06/27/24 at 11:00 A.M. with the DON confirmed the facility did not file an SRI related to the bruising of unknown origin to Resident #10's face documented on 06/10/24 and 06/12/24. Interview on 06/27/24 at 11:15 A.M. with UM #148 confirmed she completed the incident report and investigation for Resident #10's bruise but she did not consider filing an SRI. She confirmed the cognitively impaired residents were not evaluated for skin issues after the bruising was identified on Resident #10 and after STNA #137 reported the issues with Resident #10's care. Interview on 07/01/24 at 11:00 A.M. with Unit Manager #148 confirmed she signed the hospice progress note for Resident #10 on 06/10/24 but was unaware Resident #10 had a bruise. Review of the facility abuse policy dated 10/14/22 revealed allegations of abuse including injuries of unknown origin should be reported to the state agency within two hours of the allegation and no later than 24 hours. This deficiency represents noncompliance investigated under Complaint Number OH00154913.

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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** 36648 Based on medical record review, observation, resident interview, staff interview, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to thoroughly investigate an injury of unknown origin and failed to protect the resident from potential abuse. This affected one (Resident #10) of three residents reviewed for abuse. The census was 84 residents. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including heart disease, dementia without behavioral disturbances, mood, anxiety and protein calorie malnutrition. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 03/23/24 revealed the resident was severely cognitively impaired and required the assistance of one staff member for bed mobility, dressing and personal hygiene and used a wheelchair for mobility. Review of the hospice visit report for Resident #10 dated 06/10/24 per Hospice Registered Nurse (RN)#600 revealed the resident had a bruise to the right cheek and the aide reported they were unaware of the origin of the bruise. Unit Manager (UM) #148 signed the report. Review of the incident report for Resident #10 dated 06/12/24 revealed the resident had a black eye. Further review of the report revealed State tested Nursing Assistant (STNA) #137 reported to Unit Manager (UM) # 148 she was giving incontinence care during the night on 6/11/24 and Resident #10 hit her glasses and possibly her head on the arm of a chair placed against the right side of the bed. Review of the investigation for the bruise to Resident #10 dated 6/12/24 revealed the resident could not recall how the incident occurred. State tested Nursing Assistant (STNA) #137 reported Resident #10 was agitated while she was giving P.M. care and while she was rolling Resident#10, the resident bumped her face on the chair next to the bed. Review of a timeline written by the Director of Nursing (DON) dated 6/12/24 revealed UM #148 interviewed all residents following Resident #10's bruise to determine if there were any abuse concerns. The document did not include assessment of cognitively impaired residents for bruising on their skin or injuries of unknown origin. Further review revealed STNA #137 was educated in abuse, dementia care, and customer service and was assigned to work on the day shift for two shifts for additional training. The document did not include education of other staff or interviews with other staff who may have had knowledge of how the bruise occurred. Review of the facility Self-Reported Incidents (SRIs) revealed there were no reports filed for Resident #10's injury of unknown origin identified on 06/10/24 and 06/12/24. Interview on 06/20/24 at 10:36 A.M. with Resident # 55 confirmed she was concerned about Resident #10 having a black eye and she believed it was from a night shift aid giving care. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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	365627	A. Building B. Wing	07/01/2024

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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	Observation on 06/20/24 at 10:40 A.M. of Resident #10 revealed the resident had bruising under her right eye and down her right side of cheek with dark color and yellowing. Resident #10 wore glasses which sat on her right cheek on the bruise extending from her right eye. (Resident #10 was non-interviewable.) Interviews with STNA #137 were attempted by telephone on 06/20/24 at 2:30 P. M. and on 06/24/24 at 3:15 P.M. but were unsuccessful. Interview on 06/27/24 at 9:18 A. M. with Hospice RN #600 confirmed she visited Resident #10 on 06/10/24 and identified a bruise on the resident's right cheek. RN #600 further confirmed she asked an STNA how the bruise occurred, but they didn't know. RN #600 confirmed the resident was unable to explain how she was bruised. RN #600 confirmed she reported the bruising to UM #148 and had the facility nurse sign the note dated 06/10/24 which noted the bruising. Interview on 06/27/24 at 11:00 A.M. with the DON confirmed the facility did not initiate an investigation of abuse related to the bruising to Resident #10's face which was first documented on 06/10/24. The DON further confirmed the facility investigated the bruising documented on 06/12/24 but did not complete a full abuse investigation. The DON confirmed the facility investigation did not include assessment of like residents for injuries of unknown origin, did not include interviews with other staff who may have had knowledge of the incident, and did not include measures to protect the resident during the investigation. Interview on 06/27/24 at 11:15 A.M. with UM #148 confirmed she completed the incident report and investigation for Resident #10's bruise but she did not consider filing an SRI. She confirmed the cognitively impaired residents were not evaluated for skin issues after the bruising was identified on Resident #10 and after STNA #137 reported the issues with Resident #10's care. Interview on 06/27/24 at 9:18 A. M. with Hospice RN #600 confirmed she visited Resident #10 on 06/10/24 and identified a bruise on the resident's right cheek. RN #600 further confirmed she asked an STNA how the bruise occurred, but they didn't know. RN #600 confirmed the resident was unable to explain how she was bruised. RN #600 confirmed she reported the bruising to UM #148 and had the facility nurse sign the note dated 06/10/24 which noted the bruising. Interview on 07/01/24 at 11:00 A.M. with Unit Manager #148 confirmed she signed the hospice progress note for Resident #10 on 06/10/24 but was unaware Resident #10 had a bruise. Review of the facility abuse policy dated 10/14/22 revealed allegations of abuse including injuries of unknown origin should be thoroughly investigated and the facility should protect residents from abuse during the investigation. This deficiency represents noncompliance investigated under Complaint Number OH00154913.