

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 12/30/2024
NAME OF PROVIDER OR SUPPLIER Laurels of Huber Heights The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303</p> <p>Based on record review, observation, resident and staff interviews, and review of facility policy, the facility failed to ensure staff timely answered a resident's call light. This affected one (#9) of six residents reviewed for call lights. The census was 83.</p> <p>Findings include:</p> <p>Review Resident #9's medical record revealed an admitted [DATE]. Diagnoses listed included type two diabetes mellitus, hypertension, major depressive disorder, and acute kidney failure.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had moderate cognitive impairment, was frequently incontinent of bowel, and had a indwelling urinary catheter.</p> <p>Observation on 12/23/24 at 10:04 A.M. revealed the call light was on for Resident #9's room. The light above the door was illuminated and an audible beeping could be heard. At 10:12 A.M. Licensed Practical Nurse (LPN) #160 could be seen sitting at the nurse's station at the end of the hall. Resident #9's room call light remained on. At 10:25 A.M. LPN #160 walked by Resident #9's room and LPN #160 did not address the call light. At 10:26 A.M. the Administrator and entered Resident #9's room to answer the call light.</p> <p>During an interview on 12/23/24 at 10:29 A.M. interview with the Administrator revealed Resident #9 had his call light on to ask to had incontinence brief changed. The Administrator confirmed a call light should be answered timely. The Administrator confirmed confirmed 22 minutes was not considered timely. The Administrator confirmed any staff member can address a resident call light. The Administrator confirmed LPN #160 should have addressed Resident #9's call light.</p> <p>Interview with Resident #9 on 12/23/24 at 12/23/24 at 10:33 A.M. revealed he had his call light on due to concerns with his urinary catheter leaking. Resident #9 stated it takes awhile to have call lights answered.</p> <p>Review of the facility policy titled Call Lights dated effective 04/01/22 revealed call lights should be answered in a timely manner.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160868.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365627
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303</p> <p>Based on record review, observation, resident and staff interviews, and review of facility policy, the facility failed to ensure a resident's call light was kept within reach. The affected one (#7) of six residents reviewed for call lights. The census was 83.</p> <p>Findings include:</p> <p>Review of Resident #7's medical record revealed an admitted [DATE]. Diagnoses listed included type two diabetes mellitus, vascular dementia, and glaucoma.</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact.</p> <p>Observation on 12/23/24 at 8:40 A.M. revealed Licensed Practical Nurse (LPN) #170 asked Resident #7 to put on her call light so an aide could assist her with getting out of bed. Resident #7 could not find her call light. Resident #7 stated she could not find her call light all night. LPN #170 looked for Resident #7's call light and found it behind a dresser drawer cabinet located to the left and behind Resident #7's bed. LPN #170 had to move the dresser drawer cabinet to get Resident #7's call light.</p> <p>During an interview during the observation on 12/23/24 at 8:40 A.M. LPN #170 stated that stuff like this happens a lot. LPN #170 confirmed she was referring to call lights being found not within a residents' reach. LPN #170 confirmed Resident #7's call light was not within her reach.</p> <p>Review of the facility policy titled Call Lights dated effective 04/01/22 revealed call lights should be within a resident's reach.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160868.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303</p> <p>Based on observation, staff interview, and review of facility resident census, the facility failed to ensure water temperatures were comfortable for residents. This had the potential to affect 42 (#5, #6, #7, #9, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, and #97) residents residing on the 300 and 400 halls. The census was 83.</p> <p>Findings include:</p> <p>Observation of the shower room located in the 400 hall with Maintenance Director (MD) #100 on 12/23/24 at 2:48 P.M. revealed hot water temperatures in shower stalls did not reach 105 degrees Fahrenheit (F). Water temperatures in each of two shower stalls reached a maximum temperature of 90 degrees F. MD #100 confirmed hot water temperatures only reached 90 degrees F. MD #100 denied any recent hot water concerns.</p> <p>Review of water temperature logs revealed hot water temperatures below 105 degrees F had been documented consistently since 10/25/24 on the 400 hall. Issues with 400 hall hot water and working with a local plumbing company to solve the issue was noted. Water temperatures of 89 degrees F were documented on 12/17/24, 90 degrees F on 12/16/24, and 88 degrees F on 12/10/24 on the 400 hall.</p> <p>During an interview on 12/30/24 at 10:00 A.M. the Administrator and MD #100 confirmed the 400 hall had been having hot water concerns. A local plumbing company had been contracted to fix the problem. The Administrator and MD #100 confirmed that temperatures below 105 degrees F had been documented for the 400 since October 2024. MD #100 shower room [ROOM NUMBER] hall did not reach 105 degrees F on 12/23/24. MD #100 reported he had recently adjusted a water temperature mixing valve to help correct the problem. The Administrator confirmed residents that resided in the 300 and 400 halls would take showers in the 400 hall shower room.</p> <p>Review of facility census revealed 42 (#5, #6, #7, #9, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, and #97) residents resided on the 300 and 400 halls.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160422 and Complaint Number OH00160868.</p>		