

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 01/29/2025
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 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on medical record review, staff interview, resident interview, and review of the facility policy, the facility to honor resident smoking rights. This affected one (Resident #3) of one resident reviewed for smoking. The facility identified 10 residents who smoked independently. The facility census was 85 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including cerebrovascular accident, coronary artery disease, viral hepatitis, dementia, seizure disorder, and diabetes.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #3 dated 10/13/24 revealed the resident was severely cognitively impaired and required supervision/touching assistance for eating, and substantial/maximum assistance for toileting, bed mobility, and transfers.</p> <p>Review of care plan for Resident #3 dated 10/30/24 revealed the resident wished to use smoking materials and was assessed as unsafe to smoke. The resident would go out to the smoking area and look for cigarette butts to smoke or ask other residents that smoked for cigarettes. Interventions included the following: staff members to distribute smoking materials to residents who smoke at the designated times, staff to supervise and maintain safety during smoking, staff members to maintain all smoking paraphernalia for unsafe and safe smokers such as cigarettes and lighters.</p> <p>Review of smoking assessment for Resident #3 dated 11/01/24 revealed the resident was an unsafe smoker because he couldn't safely light the smoking materials, couldn't hold the materials safely, couldn't dispose of ashes in the ashtray safely, couldn't extinguish cigarette safely, and couldn't follow the policy. The summary of the assessment revealed Resident #3 was an unsafe smoker and he would be a supervised smoker.</p> <p>Interview on 01/29/25 at 8:30 A.M with the Director of Nursing (DON) confirmed if a resident was admitted into the facility and could smoke independently the resident could smoke outside whenever they wished. If a resident was assessed as an unsafe smoker, the resident was not permitted to smoke on the facility grounds. The DON further confirmed the facility did not offer supervised smoking.</p> <p>(continued on next page)</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
		If continuation sheet Page 1 of 13

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/29/25 at 10:20 A.M. with Resident #3 confirmed the resident was able to answer questions appropriately. Resident #3 confirmed he had been a smoker for quite some time and the facility would not allow him to smoke and he didn't know why.</p> <p>Review of the facility policy titled Smoking Policy dated 10/17/23 revealed if the interdisciplinary team (IDT) determined that a resident was an unsafe smoker, the resident was required to wear a protective smoking vest/apron and should be supervised while smoking. The degree of supervision was determined by the team and was based on the smoking evaluation, the physical attributes of the smoking area, and other relevant factors. Staff members would maintain all smoking paraphernalia for all unsafe and safe smokers, e.g., cigarettes, cigars, pipes, lighter fluid, or any other matter or substance that contained a tobacco product. Staff members would distribute smoking materials to residents that were unsafe to smoke at the designated smoking times.</p> <p>Review of the facility policy titled Resident Rights dated 05/14/24 revealed the facility must promote the exercise of rights for each resident, including any who face barriers such as communication problems, hearing problems and cognition limits in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on medical record review, review of facility Self-Reported incidents (SRIs), staff interview, and review of the facility policy, the facility failed to follow and implement the abuse policy regarding allegations of abuse by failing to report abuse to the state agency in a timely manner, failing to provide abuse education as detailed in the SRI, failing to protect residents during an abuse investigation by suspending accused staff, and failing to complete a timely and thorough abuse investigation. This affected two (Residents #87 and #61) of three residents reviewed for abuse. The facility census was 85 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #87 revealed an admitted [DATE] with diagnoses including quadriplegia, thrombocytopenia, obesity, and neuromuscular dysfunction of bladder and a discharge date of [DATE].</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #87 dated 11/22/24 revealed the resident was cognitively intact and required staff assistance with activities of daily living. (ADLs.)</p> <p>Review of the progress note for Resident #87 dated 01/08/25 timed at 5:08 P.M. revealed the Administrator and Director of Nursing (DON) spoke with the resident after receiving a complaint from the insurance company on 01/03/25. Resident #87 had concerns regarding staff being lax with care, the call light not being answered immediately, staff raising their voices at him, and overall poor care. The Administrator and DON interviewed Resident #87 in his room regarding the concerns. Resident #87 reported an incident with the wound nurse, Registered Nurse (RN) #131, in which the resident characterized the nurse as physically aggressive with him and physically abusive in her language. Resident #87 further stated he did not like the way RN #131 made him feel.</p> <p>Review of the SRI for Resident #87 dated 01/08/25 revealed the hospital reported Resident #87's father alleged neglect against the facility. The Administrator and DON had met with Resident #87 on 01/04/25 due to a complaint filed by the resident's insurance company but the resident had not alleged neglect during that conversation. Resident #87 was at the hospital at the time when the hospital reported the alleged neglect and did not return to the facility. The facility investigated the allegation of neglect reported by the hospital but were unable to substantiate abuse. Further review of the SRI revealed as a result of the investigation the facility educated the staff on abuse and neglect prevention and reporting. Further review of the SRI revealed there was no documentation of education completed with the staff on abuse and neglect prevention.</p> <p>Further review of the SRIs revealed there was no SRI initiated for the complaint received from the insurance company regarding Resident #87.</p> <p>Interview on 01/29/25 at 11:04 A.M. with RN #131 confirmed she was not aware of the complaints against her from Resident #87. RN #131 reported she was never notified of the situation and was not asked to complete a statement. RN #131 also verified she was never suspended pending an investigation.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/29/25 at 1:51 P.M. with the Administrator confirmed the facility did not have documentation of staff education on abuse and neglect prevention which was to be completed as a result of the investigation of the SRI dated 01/08/25.</p> <p>Interview on 01/29/25 at 2:23 P.M. with the Administrator confirmed the facility did not complete an SRI or an investigation of the insurance company's concerns regarding Resident #87 made on 01/03/25 because he did not feel there was enough information provided by the resident that identified as abuse. The Administrator confirmed the facility did not obtain a written statement from RN #131 nor was the nurse suspended related to the allegations from Resident #87.</p> <p>2. Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnoses including occlusion and stenosis of right carotid artery and diabetes.</p> <p>Review of the MDS assessment for Resident #61 dated 12/14/24 revealed the resident was moderately cognitively impaired and required assistance with ADLs.</p> <p>Review of the facility SRI dated 01/23/25 revealed a hospital social worker called the facility Social Worker (SW) #87 on 01/15/25 and reported that former Resident #65, Resident #61's former roommate, had made allegations at the hospital that a facility nurse had threatened to withhold Resident #61's medications. The facility did not initiate an investigation of the allegation until 01/23/25 and did not interview the alleged victim, Resident #61, until 01/24/25.</p> <p>Interview on 01/28/25 at 11:41 A.M with SW #87 confirmed the hospital social worker called her on the phone on 01/15/25 and reported former Resident #65 had alleged that one of the night nurses at the facility had threatened to withhold medications from Resident #61. SW #87 confirmed she did not ask the hospital social worker any further questions and she did not make a notation of the phone call in Resident #61's record. SW #87 confirmed she reported the phone call she received from the hospital social worker to the Administrator on 01/16/25.</p> <p>Interview on 01/28/25 at 11:53 A.M. with the Administrator confirmed SW #87 notified him on 01/16/25 of the call she received from the hospital social worker on 01/15/25 regarding Resident #65's allegation that a facility night nurse threatened to withhold medication from Resident #61. The Administrator confirmed he did not initiate the SRI regarding the allegation until 01/23/25.</p> <p>Review of the facility policy titled Abuse Prohibition Policy dated 10/14/22 revealed each resident should be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. All facility staff and volunteers should be in-serviced upon first employment and at least annually thereafter regarding guest/resident's right; including freedom from abuse, neglect, mistreatment, exploitation, and misappropriation of property. It was the responsibility of all staff to provide a safe environment for the guests/residents. Allegations of resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies, physician, families, and/or representative. If the accused was an employee of the facility, he/she would be suspended until the investigation had been completed.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00161688.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on medical record review, review of facility Self-Reported incidents (SRIs), staff interview, and review of the facility policy, the facility failed to report allegations of abuse to the state agency in a timely manner. This affected two (Residents #87 and #61) of three residents reviewed for abuse. The facility census was 85 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #87 revealed an admitted [DATE] with diagnoses including quadriplegia, thrombocytopenia, obesity, and neuromuscular dysfunction of bladder and a discharge date of [DATE].</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #87 dated 11/22/24 revealed the resident was cognitively intact and required staff assistance with activities of daily living. (ADLs.)</p> <p>Review of the progress note for Resident #87 dated 01/08/25 timed at 5:08 P.M. revealed the Administrator and Director of Nursing (DON) spoke with the resident after receiving a complaint from the insurance company on 01/03/25. Resident #87 had concerns regarding staff being lax with care, the call light not being answered immediately, staff raising their voices at him, and overall poor care. The Administrator and DON interviewed Resident #87 in his room regarding the concerns. Resident #87 reported an incident with the wound nurse, Registered Nurse (RN) #131, in which the resident characterized the nurse as physically aggressive with him and physically abusive in her language. Resident #87 further stated he did not like the way RN #131 made him feel.</p> <p>Review of the SRI for Resident #87 dated 01/08/25 revealed the hospital reported Resident #87's father alleged neglect against the facility. The Administrator and DON had met with Resident #87 on 01/04/25 due to a complaint filed by the resident's insurance company but the resident had not alleged neglect during that conversation. Resident #87 was at the hospital at the time when the hospital reported the alleged neglect and did not return to the facility. The facility investigated the allegation of neglect reported by the hospital but were unable to substantiate abuse. Further review of the SRI revealed as a result of the investigation the facility educated the staff on abuse and neglect prevention and reporting.</p> <p>Further review of the SRIs revealed there was no SRI initiated regarding the complaint received from the insurance company regarding Resident #87.</p> <p>Interview on 01/29/25 at 11:04 A.M. with RN #131 confirmed she was not aware of the complaints against her from Resident #87. RN #131 reported she was never notified of the situation and was not asked to complete a statement. RN #131 also verified she was never suspended pending an investigation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/29/25 at 2:23 P.M. with the Administrator confirmed the facility did not complete an SRI or an investigation of the insurance company's concerns regarding Resident #87 made on 01/03/25 because he did not feel there was enough information provided by the resident that identified as abuse. The Administrator confirmed the facility did not obtain a written statement from RN #131 nor was the nurse suspended related to the allegations from Resident #87.</p> <p>2. Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnoses including occlusion and stenosis of right carotid artery and diabetes.</p> <p>Review of the MDS assessment for Resident #61 dated 12/14/24 revealed the resident was moderately cognitively impaired and required assistance with ADLs.</p> <p>Review of the facility SRI dated 01/23/25 revealed a hospital social worked called the facility Social Worker (SW) #87 on 01/15/25 and reported that former Resident #65, Resident #61's former roommate, had made allegations at the hospital that a facility nurse had threatened to withhold Resident #61's medications. The facility did not initiate an investigation of the allegation until 01/23/25 and did not interview the alleged victim, Resident #61, until 01/24/25.</p> <p>Interview on 01/28/25 at 11:41 A.M with SW #87 confirmed the hospital social worker called her on the phone on 01/15/25 and reported former Resident #65 had alleged that one of the night nurses at the facility had threatened to withhold medications from Resident #61. SW #87 confirmed she did not ask the hospital social worker any further questions and she did not make a notation of the phone call in Resident #61's record. SW #87 confirmed she reported the phone call she received from the hospital social worker to the Administrator on 01/16/25.</p> <p>Interview on 01/28/25 at 11:53 A.M. with the Administrator confirmed SW #87 notified him on 01/16/25 of the call she received from the hospital social worker on 01/15/25 regarding Resident #65's allegation that a facility night nurse threatened to withhold medication from Resident #61. The Administrator confirmed he did not initiate the SRI regarding the allegation until 01/23/25</p> <p>Review of the facility policy titled Abuse Prohibition Policy dated 10/14/22 revealed each resident should be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. All facility staff and volunteers should be in-serviced upon first employment and at least annually thereafter regarding guest/resident's right; including freedom from abuse, neglect, mistreatment, exploitation, and misappropriation of property. It was the responsibility of all staff to provide a safe environment for the guests/residents. Allegations of resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies, physician, families, and/or representative. If the accused was an employee of the facility, he/she would be suspended until the investigation had been completed.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00161688.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on medical record review, review of facility Self-Reported incidents (SRIs), staff interview, and review of the facility policy, the facility failed to complete timely and thorough investigations and failed to protect residents during an abuse investigation by suspending accused staff. This affected two (Residents #87 and #61) of three residents reviewed for abuse. The facility census was 85 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #87 revealed an admitted [DATE] with diagnoses including quadriplegia, thrombocytopenia, obesity, and neuromuscular dysfunction of bladder and a discharge date of [DATE].</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #87 dated 11/22/24 revealed the resident was cognitively intact and required staff assistance with activities of daily living. (ADLs.)</p> <p>Review of the progress note for Resident #87 dated 01/08/25 timed at 5:08 P.M. revealed the Administrator and Director of Nursing (DON) spoke with the resident after receiving a complaint from the insurance company on 01/03/25. Resident #87 had concerns regarding staff being lax with care, the call light not being answered immediately, staff raising their voices at him, and overall poor care. The Administrator and DON interviewed Resident #87 in his room regarding the concerns. Resident #87 reported an incident with the wound nurse, Registered Nurse (RN) #131, in which the resident characterized the nurse as physically aggressive with him and physically abusive in her language. Resident #87 further stated he did not like the way RN #131 made him feel.</p> <p>Review of the SRI for Resident #87 dated 01/08/25 revealed the hospital reported Resident #87's father alleged neglect against the facility. The Administrator and DON had met with Resident #87 on 01/04/25 due to a complaint filed by the resident's insurance company but the resident had not alleged neglect during that conversation. Resident #87 was at the hospital at the time when the hospital reported the alleged neglect and did not return to the facility. The facility investigated the allegation of neglect reported by the hospital but were unable to substantiate abuse. Further review of the SRI revealed as a result of the investigation the facility educated the staff on abuse and neglect prevention and reporting. Further review of the SRI revealed there was no documentation of education completed with staff on abuse and neglect prevention.</p> <p>Further review of the SRIs revealed there was no SRI initiated regarding the complaint received from the insurance company regarding Resident #87.</p> <p>Interview on 01/29/25 at 11:04 A.M. with RN #131 confirmed she was not aware of the complaints against her from Resident #87. RN #131 reported she was never notified of the situation and was not asked to complete a statement. RN #131 also verified she was never suspended pending an investigation.</p> <p>Interview on 01/29/25 at 1:51 P.M. with the Administrator confirmed the facility did not have documentation of staff education on abuse and neglect prevention which was to be completed as a result of the investigation of the SRI dated 01/08/25.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/29/25 at 2:23 P.M. with the Administrator confirmed the facility did not complete an SRI or an investigation of the insurance company's concerns regarding Resident #87 made on 01/03/25 because he did not feel there was enough information provided by the resident that identified as abuse. The Administrator confirmed the facility did not obtain a written statement from RN #131 nor was the nurse suspended related to the allegations from Resident #87.</p> <p>2. Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnoses including occlusion and stenosis of right carotid artery and diabetes.</p> <p>Review of the MDS assessment for Resident #61 dated 12/14/24 revealed the resident was moderately cognitively impaired and required assistance with ADLs.</p> <p>Review of the facility SRI dated 01/23/25 revealed a hospital social worker called the facility Social Worker (SW) #87 on 01/15/25 and reported that former Resident #65, Resident #61's former roommate, had made allegations at the hospital that a facility nurse had threatened to withhold Resident #61's medications. The facility did not initiate an investigation of the allegation until 01/23/25 and did not interview the alleged victim, Resident #61, until 01/24/25.</p> <p>Interview on 01/28/25 at 11:41 A.M with SW #87 confirmed the hospital social worker called her on the phone on 01/15/25 and reported former Resident #65 had alleged that one of the night nurses at the facility had threatened to withhold medications from Resident #61. SW #87 confirmed she did not ask the hospital social worker any further questions and she did not make a notation of the phone call in Resident #61's record. SW #87 confirmed she reported the phone call she received from the hospital social worker to the Administrator on 01/16/25.</p> <p>Interview on 01/28/25 at 11:53 A.M. with the Administrator confirmed SW #87 notified him on 01/16/25 of the call she received from the hospital social worker on 01/15/25 regarding Resident #65's allegation that a facility night nurse threatened to withhold medication from Resident #61. The Administrator confirmed he did not initiate the SRI regarding the allegation until 01/23/25</p> <p>Review of the facility policy titled Abuse Prohibition Policy dated 10/14/22 revealed each resident should be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. All facility staff and volunteers should be in-serviced upon first employment and at least annually thereafter regarding guest/resident's right; including freedom from abuse, neglect, mistreatment, exploitation, and misappropriation of property. It was the responsibility of all staff to provide a safe environment for the guests/residents. Allegations of resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator and reported to the appropriate state agencies, physician, families, and/or representative. If the accused was an employee of the facility, he/she would be suspended until the investigation had been completed.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00161688.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to provide the appropriate level of supervision to prevent accidents involving residents while smoking cigarettes. This affected one (Resident #3) of one resident reviewed for smoking practices. The facility identified 10 residents in the facility who smoked independently. The facility census was 85 residents.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including cerebrovascular accident, coronary artery disease, viral hepatitis, dementia, seizure disorder, and diabetes.</p> <p>Review of the annual Minimum Data Set (MDS) assessment for Resident #3 dated 10/13/24 revealed the resident was severely cognitively impaired and required supervision/touching assistance for eating and substantial/maximal assistance for toileting, bed mobility, and transfers.</p> <p>Review of care plan for Resident #3 dated 10/30/24 revealed the resident wished to use smoking materials and was assessed as unsafe to smoke. The resident would go out to the smoking area and look for cigarette butts to smoke or ask other residents that smoke for cigarettes. Interventions included the following: staff members to distribute smoking materials to residents who smoke at the designated times, staff to supervise and maintain safety of residents during smoking, staff members to maintain all smoking paraphernalia for unsafe and safe smokers such as cigarettes and lighters.</p> <p>Review of the smoking assessment for Resident #3 dated 11/01/24 revealed the resident was an unsafe smoker because he couldn't safely light the smoking materials, couldn't hold the materials safely, couldn't dispose of ashes in the ashtray safely, couldn't extinguish cigarettes safely, and couldn't follow the policy. The summary of the assessment revealed Resident #3 was an unsafe smoker and he should be supervised while smoking.</p> <p>Review of the progress note for Resident #3 dated 12/21/24 revealed the resident was sitting outside of the nursing station and Registered Nurse (RN) #113 noticed a smoke smell and saw Resident #3 with smoke coming from his left pant leg with an ember lit area. Staff put out the embers with water and assisted Resident #3 with changing his clothes. The nurse completed a skin check following the incident of unsupervised smoking and noted a small, reddened area to the top of resident's left thigh.</p> <p>Interview on 01/28/25 at 3:30 P.M. with the Administrator confirmed Resident #3 was an unsafe smoker and had poor safety awareness. The Administrator confirmed the resident should be monitored for safety while smoking to ensure the safety of the resident and the other residents in the facility.</p> <p>(continued on next page)</p>		

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 01/29/2025
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.			
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/28/25 at 3:43 P.M. with RN #113 confirmed on 12/21/24 Resident #3 was sitting by the nursing station and the nurse smelled smoke and saw Resident #3 had smoke coming from his paint leg with a lit ember. Staff threw water on the resident and the ember was extinguished. RN #113 did a skin assessment on the Resident #3 and discovered a small, reddened area to the top of the resident's left upper thigh. RN #113 confirmed Resident #3 wasn't supposed to go out to smoke, but he had a behavior of going outside and getting cigarette butts left by other resident smokers. RN #113 believed Resident #3 had gotten a lit cigarette butt which caused the injury to his upper thigh.</p> <p>Review of the facility policy titled Smoking Policy dated 10/17/23 revealed if the interdisciplinary team (IDT) determined that the resident was an unsafe smoker, the resident was required to wear a protective smoking vest/apron and was to be supervised while smoking. The degree of supervision was determined by the team and was based on the smoking evaluation, the physical attributes of the smoking area, and other relevant factors. Staff members would maintain all smoking paraphernalia for all unsafe and safe smokers, e.g., cigarettes, cigars, pipes, lighter fluid, or any other matter or substance that contains a tobacco product. Staff members would distribute smoking materials to residents that were unsafe to smoke at the designated smoking times.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on medical record review, review of facility Self-Reported Incidents (SRIs), and staff interview, the facility failed to ensure the medical record was complete and included pertinent resident information. This affected one (Resident #61) of three reviewed for medical records. The facility census was 85 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnoses including occlusion and stenosis of right carotid artery and diabetes.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #61 dated 12/14/24 revealed the resident was moderately cognitively impaired and required assistance with activities of daily living (ADLs.)</p> <p>Review of the progress notes for Resident #61 dated 01/15/25 revealed there was no documentation of a phone call from the hospital social worker to the facility social worker regarding concerns of possible resident mistreatment.</p> <p>Review of the facility SRI dated 01/23/25 revealed a hospital social worker called the facility Social Worker (SW) #87 on 01/15/25 and reported that former Resident #65, Resident #61's former roommate, had made allegations at the hospital that a facility nurse had threatened to withhold Resident #61's medications.</p> <p>Interview on 01/28/25 at 11:41 A.M with SW #87 confirmed the hospital social worker called her on the phone on 01/15/25 and reported former Resident #65 had alleged that one of the night nurses at the facility had threatened to withhold medications from Resident #61. SW #87 confirmed she did not ask the hospital social worker any further questions and she did not make a notation of the phone call in Resident #61's record.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff maintained appropriate enhanced barrier precautions (EBP) during wound care and incontinence care and failed to ensure staff practiced appropriate hand hygiene during incontinence care. This affected one (Resident #23) of three residents reviewed for incontinence care and wound care. The facility census was 85 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including fracture of superior rim of left pubis, heart failure, and atrial fibrillation.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #23 dated 01/11/25 revealed the resident had intact cognition and required partial assistance with eating and transfers, substantial assistance with toileting and bathing, and was dependent with dressing.</p> <p>Review of the progress note for Resident #23 dated 01/06/25 timed at 4:10 P.M. revealed the resident had an unstageable pressure ulcer to the buttock which measured 10.5 centimeters (cm) in length by 12.2 centimeters in width.</p> <p>Review of the physician's orders for Resident #23 dated January 2025 revealed the resident did not have orders for enhanced barrier precautions (EBP).</p> <p>Observation on 01/29/25 at 8:56 A.M. of wound care for Resident #23 per Registered Nurse (RN) #131 with the assistance of Certified Nursing Assistant (CNA) #96 revealed the nurse and aide did not don gowns prior to providing wound care.</p> <p>Observation on 01/29/25 at 9:09 A.M. of incontinence care for Resident #23 per CNA #96 revealed the aide did not don a gown during care. Prior to care, CNA #96 completed hand hygiene and applied gloves. CNA #96 did not change gloves during care or after completing incontinence care. CNA #96 used soiled gloves to touch bed controls, the call light, and the bedside table after care was completed.</p> <p>Interview on 01/29/25 at 9:21 A.M. with CNA #96 confirmed she did not wear a gown when performing incontinence care or when assisting the nurse with wound care for Resident #23. CNA #96 confirmed she did not remove soiled gloves before touching the resident's bed controls, the call light, and the bedside table.</p> <p>Interview on 01/29/25 at 9:24 A.M. with RN #131 confirmed she did not wear a gown when completing wound care for Resident #23. RN #131 further confirmed she thought Resident #23 should be in EBP due to the unstageable wound and wearing a gown was required for provision of direct care for residents in EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Enhanced Barrier Precautions (EBP) dated 04/01/24 revealed EBP were indicated for residents with any of the following: infection of colonization with a Centers for Disease Control (CDC)-targeted multidrug resistant organism (MDRO), when contact precautions did not otherwise apply, resident had a wound or indwelling medical device, even if the resident was not known to be infected or colonized with a MDRO. The EBP for a resident with a wound or indwelling medical device 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. Chronic wounds generally included for EBP chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Staff should post signage for EBP precautions on the door or wall outside of the resident's room indicating type of precautions and the required personal protective equipment (PPE.). Health care personnel caring for residents on EBP should wear gloves and gowns during high-contact resident care including dressing, bathing, transferring, hygiene, changing linens, changing briefs, or wound care.</p> <p>Review of the facility policy titled Hand Hygiene dated 10/11/23 revealed hand washing was generally considered the most important single procedure for preventing healthcare-associated infections. Hand hygiene should be performed before and after contact with the resident, after contact with blood, body fluids, visibly contaminated surfaces or other objects in the resident's room, after removing personal protective equipment, and direct resident contact.</p>		