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	04/09/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, staff interviews, policy review and review of the Ohio Revised Code (ORC), the facility failed to ensure the administration of total parental nutrition (TPN) was completed in accordance with professional standards of practice. This affected two (#57 and #89) of three residents reviewed for intravenous (IV) administration. The facility census was 88. Findings include: 1. Medical record review for Resident #57 revealed an admission on 08/07/24 with diagnoses with surgical aftercare on the digestive system, fistula of intestine, chronic pain syndrome, colostomy status and protein calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #57 dated 02/27/25 revealed impaired cognition. Resident #57 required set up assistance for eating and maximum assistance for toileting assistance and dependent for transfers and bed mobility. Review of the plan of care for Resident #57 revealed resident has an alteration in nutritional and hydration related to fistula of intestine. Resident #57 has history of TPN discontinued on 11/03/24. Interventions include administer medication as ordered, administer diet as ordered and obtain laboratory/diagnostic tests as ordered. Review of the physicians orders for Resident #57 revealed an order dated 08/09/24 and discontinued on 11/03/24 for TPN adult cyclic on day shift nonstandard TPN. Registered Nurse (RN) to mix Infuvite (multivitamin) 10 milliliters (ml) start at 55 ml/hour (hr) and increase to 178 ml/hr for nine hours, decrease to 50 ml/hr for one hour the discontinue every day shift. Review of the Medication Administration Record (MAR) for Resident #57 for the month of October 2024 revealed Licensed Practical Nurse (LPN) #5 signed Resident #57's TPN as administered on 10/02/24, 10/05/24, 10/06/24, 10/10/24, 10/16/24, 10/19/24, 10/20/24, 10/24/24, 10/15/24, 10/30/24 and 10/31/24. LPN #29 signed Resident #57's TPN as administered on 10/03/24 and 10/17/24. LPN #35 signed Resident #57's TPN as administered on 10/09/24 and 10/28/24. LPN #31 signed Resident #57's TPN as administered on 10/11/24, 10/12/24, and 10/23/24. 2. Medical record review for Resident #89 revealed an admission on 06/11/24 and a discharge on 02/17/25 with diagnoses including surgical after care following digestive system for perforation of the intestine, severe protein malnutrition and adult lymphoma leukemia. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care for Resident #89 dated 06/19/24 revealed resident was at nutritional risk related to diagnoses of lymphoma. Resident #89 had a history of TPN discontinued on 12/04/24. Interventions include administer medications as ordered, refer to dietitian as needed and obtain laboratory test as ordered. Review of the quarterly MDS assessment dated [DATE] for Resident #89 revealed resident had an intact cognition. Resident #89 requires supervision for eating, bed mobility, transfers and toileting. Review of the physician's orders for Resident #89 for the month of November 2024 revealed an order dated 07/18/24 and discontinued on 12/10/24 for TPN adult cyclic on day shift nonstandard TPN, 5.5 percent (%) AA, seventeen % dextrose and three % intravenous lipid emulsion ([NAME]) kilocalorie's (KCAL) provided per day 1713 protein grams/day. RN to mix Infuvite (multivitamin) 10 milliliters (ml) start at 60 mix mix one hour, increase to 120 ml/hr times twelve house and decrease to 60 ml per hour and then discontinue every day shift for nutrition. Review of the MAR for Resident #89 for the month of November 2024 revealed LPN #31 signed the TPN as administered on 11/01/24, 11/04/24, 11/07/24, 11/09/24, 11/10/24, 11/12/24, 11/14/24, 11/15/24, 11/18/24, 11/19/24, 11/21/24, 11/23/24, 11/24/24, 11/26/24 and 11/29/24. LPN #25 signed Resident #89's TPN as administered on 11/03/24, 11/06/24, 11/08/24, 11/11/24, 11/13/24, 11/16/24, 11/17/24, 11/20/24, 11/22/24, 11/25/24, 11/27/24, 11/28/24 and 1130/24. Interview on 04/08/24 at 3:07 P.M. with the Director of Nursing (DON) states she was unaware that the LPN's were documenting on the MAR indicating they were administering the TPN solution for Resident #57 or #89. DON verified that LPN's cannot administer TPN as it is out of their scope of practice. Additionally, the DON stated that once it was brought to her attention, she interviewed the LPN's regarding who was administrating the solution. LPN's reported the RN's working administered the TPN solution and the LPN's had just signed the MAR off as completed. DON verified LPN's should not be signing for the administration of TPN or documenting it on the MAR as administered. DON confirmed LPN's can not initiate or maintain TPN. Interview on 04/08/25 at 4:09 P.M. with LPN #31 verified that he did not administer any TPN solution for Resident #57 and #89. LPN #31 only signed the MAR as completed. LPN #31 confirmed LPN's can not initiate or maintain TPN. Interview on 04/09/25 at 2:00 P.M. with Unit Manager LPN #76 denied any knowledge of any LPN's completing the administration of TPN and that they were just signing off the MAR for the RN. LPN #76 verified administration of TPN solution was out of the scope of practice for LPN's. LPN #76 confirmed LPN's can not initiate or maintain TPN. Review of the facility policy titled Total Parental Nutrition dated 12/10/24 revealed staff should monitor for signs of complications related to TPN administration. Review of the facility policy titled Medication Administration dated 10/17/23 revealed under authorized personnel medications are prepared, administered and recorded only by licensed nursing authorized by state law and regulations. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ORC Section 4723.18 titled Administration of Adult Intravenous Therapy at https://codes.ohio.gov/ohio-revised-code/section-4723.18 revealed LPN's shall not perform any of the following: initiate or maintain any intravenous therapy procedures that include solutions for total parental nutrition. This deficiency represents non-compliance investigated under Complaint Number OH00162510.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observations, staff interviews and policy review, the facility failed to ensure staff implemented enhanced barrier precautions when changing wounds that require dressings. This affected one (#26) of three residents reviewed for wound care. The facility census was 88. Findings include: Review of the medical record for Resident #26 revealed an admission on 06/18/24 with diagnoses including cerebral infarction (stroke), heart failure, end stage renal disease, type two diabetes and severe vascular dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #26 revealed a severely impaired cognition. Resident #26 requires extensive assistance for activities of daily living. Review of the plan of care for Resident #26 dated 04/02/24 revealed resident has venous stasis skin impairment to left [NAME] related to peripheral vascular disease (PVD). Interventions include skin injury will decrease in size, enhanced barrier precautions, observe and report signs and symptoms of infection, and evaluate wound for size, depth, and margins. Review of the active physician orders for Resident #26 reveal an order dated 03/15/25 to cleanse area to right frontal lateral leg, pat dry and apply adaptic (petroleum gauze), cover with abdominal dressing (ABD) and wrap with kerlix daily and as needed, an or dated 03/19/25 to cleanse laceration wound to right mid anterior shin and right mid lateral skin with normal saline, pat dry, apply xeroform to eschar, cover with ABD, wrap with Kerlix and secure with ace bandage daily, an order dated 03/29/25 to cleanse skin tear to left buttock with normal saline, apply xeroform to wound bed, cover with silicone dressing every day, and cleanse wound to left medial calf (hematoma) with normal saline, pat dry and apply xeroform, cover with ABD, wrap with kerlix daily and as needed. Observation on 04/08/25 at 8:00 A.M. of signage for Resident #26 to the right of the entrance and above her name revealed the resident was on enhanced barrier precaution. The sign stated everyone must clean their hands before entering and when leaving the room. Additionally, the sign stated that providers and staff must also wear gloves, and a gown for the following high contact resident care activities including dressing, bathing, showering, transferring, changing linen, providing briefs or assisting with toileting, device care for central line, urinary catheter, feeding tube and tracheostomy and wound care for any skin opening requiring a dressing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/08/25 at 8:10 A.M. revealed Licensed Practical Nurse (LPN) #5 and Certified Nurse Assistant (CNA) #84 enter Resident #26's room and donned gloves. LPN #5 advised Resident #26 that they were going to remove old dressing and measure the areas. LPN #5 removed the dressing to Resident #26's bilateral legs leaving dressing in place on the lower extremities. Wound Physician #101 donned gloves and entered room and addressed the resident, advising her he was there to measure the wounds. Wound Physician #101 measured each of the three wounds using separate disposable wound measuring devices. LPN #5 changed gloves completed hand hygiene and donned new gloves and applied dressing to left lower hematoma, leaving the right wound uncovered as the physician discontinued treatment and advised they were resolved. CNA #84 assisted Resident #26 to roll onto her right side for the physician to measure the wound to her left buttocks. Treatment to area was discontinued and physician documented area was resolved. Interview on 04/08/25 at 8:25 A.M. with LPN #5, CNA #84, Wound Physician #101 all verified they did not don gowns prior to entering the room for Resident #26 and should have. LPN #5, CNA #84 and Wound Physician #101 confirmed Resident #26 was to be in enhanced barrier precautions. Interview on 04/08/25 at 8:30 A.M. with the Director of Nursing (DON) verified the facility did not have a three chest drawer in the hallway to store personal protective equipment for use with Resident #26 and would get one in place outside of the door for Resident #26. The DON confirmed Resident #26 was to be in enhanced barrier precautions. Review of the facility policy titled Infection Preventions Program Overview dated 02/28/25 stated the facility established a program (infection prevention and control program) that is based on the facility assessment and follows accepted national standards. This deficiency represents non-compliance investigated under Complaint Number OH00162510.