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	09/11/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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F 0684 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 medical record reviews, staff interview, and policy review, the facility failed to complete wound assessments at the time of admission and/or failed to timely initiate treatment for wounds. This affected two (#16 and #32) out of three residents reviewed for wounds. The facility census was 75. Findings include: 1.Review of the medical record for Resident #16 revealed an admission date of 05/23/25 with medical diagnoses of aftercare following surgical amputation, peripheral vascular disease, end stage renal disease, and diabetes mellitus (DM). Review of a quarterly Minimum Data Set (MDS) assessment, dated 08/16/25, indicated Resident #16 was cognitively intact and required substantial/maximum staff assistance for toilet hygiene and bathing, partial/moderate staff assistance for bed mobility and was dependent upon staff for transfers. The MDS indicated Resident #16 admitted with two deep tissue injuries (DTI), DM foot ulcer, and surgical wound. Review of a nursing comprehensive assessment, dated 05/23/25, indicated under the skin assessment that Resident #16 had right toe amputation, redness to bilateral buttocks, coccyx, and heels. The assessment did not contain documentation to support measurements or description of skin issues. Review of wound/skin evaluations completed 05/28/25 indicated Resident #16 admitted with a vasculitic injury to left dorsum fifth digit (toe) which measured 2.0 centimeters (cm) by 1.8 cm with 20% slough and 50% eschar, a vasculitic injury to left heel which measured 4.2 cm by 3.2 cm and had 100% eschar, an other skin issue to right lateral malleolus which measured 3.0 cm by 2.5 cm with 100% eschar, a DTI to right heel which measured 5.2 cm by 3.8 cm with 100% eschar, an other skin issue to left lateral malleolus which measured 1.6 cm by 1.2 cm with 100% eschar, a surgical site to right dorsum first digit with partial dehiscence which measured 8.7 cm by 3.6 cm, an other skin issue to right dorsum foot which measured 1.9 cm by 1.3 cm, an other skin issue to left lateral midfoot which measured 2.1 cm by 1.9 cm and moisture associated skin damage (MASD) to sacrum with no measurements noted. Review of the physician orders for Resident #16 revealed no documentation to support treatment was initiated for the above wounds until 05/29/25. Review of medical record for Resident #16 revealed documentation to support Resident #16 was seen by a wound physician weekly starting 06/03/25 until discharged on 06/27/25. Review of the wound physician note dated 06/24/25 indicated Resident #16 had a DTI ulcer to left heel, unstageable pressure ulcer to right anterior ankle (formerly documented as right lateral malleolus), a surgical wound to right distal foot, an unstageable pressure ulcer to right dorsal foot, and a DTI to right heel. Interview on 09/11/25 at 10:45 A.M. with Licensed Practical Nurse (LPN) #203 confirmed the medical record for Resident #16 did not have documentation to support the wounds were evaluated upon admission on [DATE] until 05/28/25 and that a treatment for the wounds was not initiated until 05/29/25. 2. Review of the medical record for Resident #32 revealed an admission date of 07/17/25 with medical diagnoses of diabetes mellitus with foot ulcer, chronic ulcer of left heel and midfoot with fat layer exposed, congestive heart failure, anemia, and atrial fibrillation. Review of the admission MDS assessment, dated 07/24/25, indicated Resident #32 was cognitively intact and required partial/moderate staff assistance for bed mobility and was dependent upon staff for toilet hygiene, showers/bathing, and transfers. The MDS indicated Resident #32 had an infection to her foot with a surgical wound present. Review of nursing comprehensive assessment, dated 07/17/25, indicated Resident #32 had stitches to left small toe and left outer foot. The assessment did not include measurements or description of wounds. Review of medical record for Resident #32 revealed a physician order dated 07/18/25 for left foot surgical site to apply Vashe moistened gauze to surgical site five to ten minutes then remove, pat dry, apply xerofoam, abdominal pad, and wrap with kerlix and ace wrap. And to change every 48 hours. Review of treatment administration record revealed documentation to support treatment was completed as ordered. Review of the medical record for Resident #32 revealed documentation to support Resident #32 was seen by wound physician on 07/22/25. A wound physician note on 07/22/25 indicated Resident #32 had surgical site to left lateral foot which measured 6.5 cm by 2.5 cm with five interrupted sutures in place. Interview on 09/11/25 at 11:26 A.M. with LPN #203 confirmed Resident #32 admitted to the facility with surgical wounds on 07/17/25 but the medical record did not have documentation to support Resident #32 wounds were not measured until 07/22/25. Review of the facility policy titled, Skin Management, revised 09/19/24, stated the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. The policy stated upon admission/re-admission all residents are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic health record. The policy

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to complete pressure ulcer assessments upon admission and failed to timely initiate treatment for pressure ulcers. This affected one (#16) out of the three residents reviewed for pressure ulcers. The facility census was 75. Findings include: Review of the medical record for Resident #16 revealed an admission date of 05/23/25 with medical diagnoses of aftercare following surgical amputation, peripheral vascular disease, end stage renal disease, and diabetes mellitus (DM). Review of a quarterly Minimum Data Set (MDS) assessment, dated 08/16/25, indicated Resident #16 was cognitively intact and required substantial/maximum staff assistance for toilet hygiene and bathing, partial/moderate staff assistance for bed mobility and was dependent upon staff for transfers. The MDS indicated Resident #16 admitted with two deep tissue injuries (DTI), DM foot ulcer, and surgical wound. Review of a nursing comprehensive assessment, dated 05/23/25, indicated under the skin assessment that Resident #16 had right toe amputation, redness to bilateral buttocks, coccyx, and heels. The assessment did not contain documentation to support measurements or description of skin issues. Review of wound/skin evaluations completed 05/28/25 indicated Resident #16 admitted with a vasculitic injury to left dorsum fifth digit (toe) which measured 2.0 centimeters (cm) by 1.8 cm with 20% slough and 50% eschar, a vasculitic injury to left heel which measured 4.2 cm by 3.2 cm and had 100% eschar, an other skin issue to right lateral malleolus which measured 3.0 cm by 2.5 cm with 100% eschar, a DTI to right heel which measured 5.2 cm by 3.8 cm with 100% eschar, an other skin issue to left lateral malleolus which measured 1.6 cm by 1.2 cm with 100% eschar, a surgical site to right dorsum first digit with partial dehiscence which measured 8.7 cm by 3.6 cm, an other skin issue to right dorsum foot which measured 1.9 cm by 1.3 cm, an other skin issue to left lateral midfoot which measured 2.1 cm by 1.9 cm and moisture associated skin damage (MASD) to sacrum with no measurements noted. Review of the physician orders for Resident #16 revealed no documentation to support treatment was initiated for the above wounds until 05/29/25. Review of medical record for Resident #16 revealed documentation to support Resident #16 was seen by a wound physician weekly starting 06/03/25 until discharged on 06/27/25. Review of the wound physician note dated 06/24/25 indicated Resident #16 had a DTI ulcer to left heel, unstageable pressure ulcer to right anterior ankle (formerly documented as right lateral malleolus), a surgical wound to right distal foot, an unstageable pressure ulcer to right dorsal foot, and a DTI to right heel. Interview on 09/11/25 at 10:45 A.M. with Licensed Practical Nurse (LPN) #203 confirmed the medical record for Resident #16 did not have documentation to support the wounds were evaluated upon admission on [DATE] until 05/28/25 and that a treatment for the wounds was not initiated until 05/29/25. Review of the facility policy titled, Skin Management, revised 09/19/24, stated the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. The policy stated upon admission/re-admission all residents are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic health record. The policy stated any residents admitted with any skin impairment would have appropriate interventions to promote healing, a physician's order for treatment and skin impairment location, measurements, and characteristics documented. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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. Based on medical record review, observation, staff interview, and policy review, the facility failed to follow infection control procedures during medication administration. This affected one (#20) out of two residents observed for medication administration. The facility census was 75. Findings include: Review of the medical record for Resident #20 revealed an admission date of 12/30/21 with medical diagnoses of cerebral infarction, dysphagia, vascular dementia, hypertension, and diabetes mellitus. Review of the medical record for Resident #20 revealed physician orders dated 08/03/24 for Oyster Calcium tablet 500 milligram (mg) one tablet by mouth daily, galantamine 12 mg one tablet by mouth daily, and Memantine 5 mg one tablet by mouth daily, physician orders dated 08/04/25 for aspirin 81 mg one tablet by mouth daily, chlorthalidone 12.5 mg one tablet by mouth daily, senna 8.6-50 mg one tablet by mouth daily, nifedipine 90 mg one tablet by mouth daily, and an order for Depakote 125 mg three tablets by mouth three times per day. Observation on 09/11/25 at 9:05 A.M. revealed Licensed Practical Nurse (LPN) #207 prepared medications for Resident #20 and was observed placing aspirin tablet, Oyster Calcium tablet, and senna tablet into her bare hands prior to placing the medications into the medication cup. LPN #207 was observed placing medications into a plastic sleeve and crushing the medications prior to placing them into a medication cup along with applesauce. LPN #207 was observed to administer medications to Resident #207. Interview won 09/11/25 at 9:27 A.M. with LPN #207 confirmed she placed Resident #20's aspirin, Oyster Calcium tablet, and senna tablet into her bare hands prior to medication administration. Review of the facility policy titled, Medication Administration, revised 10/17/23 stated resident medications are to be administered in an accurate, safe, timely, and sanitary manner. The policy stated medications are administered in accordance with written orders of the attending physician. The policy stated staff are to perform hand hygiene prior to medication preparation for each medication pass and after direct resident contact. The policy stated to place medications in medicine cups without touching the inside of the cup and if medications come into contact with the bare hands of the nurse/med tech or with the care, the medication should be disposed of per policy and new medications obtained. This deficiency is based on incidental findings discovered during the course of this complaint investigation.