STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365656	A. Building B. Wing	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of New London The	204 W Main St New London, OH 44851

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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to provide a notice of the bed hold policy to residents when transferred from the facility to a hospital. This affected five (#12, #20, #22, #50, and #102) of five residents reviewed for bed hold notices. The facility census was 44. Findings include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included hypertension, dysphagia, atrial fibrillation, and chronic diastolic heart failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had intact cognition. Review of a nursing progress note dated 09/24/24 revealed Resident #50 was sent to the emergency room due to increased confusion. There was no documentation the resident was given a notice of the facility's bed hold policy. 2. Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included lymphoma, acute on chronic systolic heart failure, hypertension, and atrial fibrillation. Review of the admission MDS assessment dated [DATE] revealed Resident #12 had intact cognition. Review of the nursing progress note dated 09/27/24 at 11:08 A.M. revealed Resident #12 was sent to the emergency room for abdominal pain. Further review of the nursing progress notes revealed the resident was admitted to the hospital. There was no documentation the resident was provided with a notice of the facility's bed hold policy. 3. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included osteomyelitis, type two diabetes mellitus, hypertension, and chronic kidney disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #22 had intact cognition. (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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of a nursing progress note dated 11/26/24 at 9:57 P.M. revealed Resident #22 was admitted to the hospital for an infection. There was no documentation the resident was provided with a notice of the facility's bed hold policy. 4. Review of the medical record for Resident #102 revealed an admitted [DATE]. Diagnoses included heart failure, chronic systolic heart failure, Alzheimer's disease, type two diabetes mellitus, chronic kidney disease, and atrial fibrillation. Review of the admission MDS assessment dated [DATE] revealed Resident #102 had severe cognitive impairment. Review of the nursing progress notes dated 12/07/24 at 8:28 P.M. revealed Resident #102 was admitted to the hospital for bradycardia and shortness of breath. There was no documentation the resident was provided with a notice of the facility's bed hold policy. 5. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included pneumonia, Alzheimer's disease, type two diabetes mellitus, chronic kidney disease and hypertension. Review of the admission MDS assessment dated [DATE] revealed Resident #20 had mild cognitive impairment. Review of a nursing progress note dated 12/09/24 at 7:05 A.M. revealed Resident #20 was admitted to the hospital for a hemothorax, right side rib fracture, and pneumonia. There was no documentation the resident was provided with a notice of the facility's bed hold policy. Interview on 12/24/24 at 10:55 A.M., the Administrator verified Resident #12, Resident #20, Resident #22, Resident #50, and Resident #102 were not provided with the notice of the bed hold policy when they were transferred from the facility to a hospital. The Administrator revealed the facility was not providing the notice of bed hold policy to residents with Medicare insurance. Review of the policy titled, Bed Hold and Return to Facility, dated 12/2016, revealed the facility would provide written information to the resident or resident's representative of the bed hold policy upon leaving for hospitalization or a therapeutic leave.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, observation, staff interview, and facility policy, the facility failed to ensure fall interventions were implemented in accordance with physician orders. This affected one (#35) of three residents reviewed for falls. The facility census was 44. Findings include: Review of Resident #35's medical record revealed an admitted [DATE]. Diagnoses included dementia, abnormal posture, muscle weakness, hypertension, glaucoma, lumbago with sciatica on right and left sides, and depression. Review of Resident #35's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively impaired. The resident required substantial to maximal assistance from staff for toileting. Review of Resident #35's plan of care, revised 07/15/24, revealed the resident was at risk for falls and fall-related injuries related to confusion, deconditioning, gait/balance problems, incontinence, safety unawareness, psychoactive drug use, and diagnoses. Interventions included providing assistive devices as needed, keeping the call light in reach, and placing a sign in the room and bathroom to remind the resident to call for help with transfers. Review of Resident #35's active physician orders on 12/23/24 identified an order dated 10/24/23 for a sign in the room and bathroom to remind the resident to call for help with transfers. Observation on 12/23/24 at 9:02 A.M. revealed Resident #35 was sitting up in a reclining chair located in the resident's room. There was no signage in the room or in the resident's bathroom to remind the resident to call for assistance. An observation and interview on 12/23/24 at 11:20 A.M. with Certified Nurse Aide (CNA) #492 verified there was no sign in Resident #35's room or bathroom to remind the resident to call for assistance with transfers.