STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365773	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Kettering	694 Isaac Prugh Way Kettering, OH 45429

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, staff interview, record review, and policy review, the facility failed to timely identify and treat a resident's skin tear. This affected one (Resident #28) of three residents reviewed for wound care. The facility census was 87. Findings include: Review of the medical record revealed Resident #28 was admitted to the facility on [DATE]. Diagnoses included non-ischemic myocardial injury, rhabdomyolysis, chronic atrial fibrillation, stage III kidney disease, and chronic systolic heart failure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #28 had severely impaired cognition, had no behaviors, did not reject care, and did not wander. Review of the Nursing Comprehensive Evaluation dated 06/20/24 revealed Resident #28 had no skin conditions documented, and there was no data to trigger a baseline care plan for potential skin breakdown. There was no mention Resident #28 had any wound to her left lower leg from 06/20/24 to 06/26/24. During an observation and interview on 06/26/24, Licensed Practical Nurse (LPN) #187 verified Resident #28 had a dressing on her left lower leg that was dated 06/19/24. LPN #187 stated Resident #28 had been due for a weekly skin assessment on 06/25/24 but it was not completed because it did not flag in the system for the nurse to complete. LPN #187 verified it was documented in the admission assessment completed 06/20/24 that Resident #28 had no skin issues. Observation of the skin tear on Resident #28's left lower leg revealed it measured 2.0 centimeters (cm) in length by 1.0 cm in width. LPN #187 cleansed the wound with normal saline and covered the wound with Xeroform gauze and a Mepilex dressing. Review of the facility policy titled Skin Management dated 05/14/24 revealed all residents were evaluated for skin integrity upon admission, and any resident with impaired skin integrity had appropriate interventions implemented to promote healing including physician's order for treatment, documentation of wound location, measurements, and characteristics, and weekly documentation until the area was resolved. This deficiency represents noncompliance investigated under Complaint Number OH00155306 and Complaint Number OH00154306.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER The Laurels of Kettering		STREET ADDRESS, CITY, STATE, ZIP CODE 694 Isaac Prugh Way Kettering, OH 45429	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observations, staff interview, review of the facility policy, and record review, the facility failed to ensure residents received incontinence care in a timely manner. This affected one (Resident #61) of six residents reviewed for toileting assistance. The facility census was 87. Findings include: Review of the medical record for Resident #6 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes, stage III chronic kidney disease, and anxiety. Review of the care plan dated 08/11/21 revealed Resident #61 was incontinent of bowel and bladder related to immobility. Interventions included to assist with toileting upon request, provide disposable briefs, check during rounds for incontinence, and provide incontinence care as needed. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact, had no behaviors, did not reject care, and did not wander. Resident #61 was always incontinent of bowel and bladder and was not on a toileting program. Observation on 07/01/24 revealed Resident #61 activated her call light at 9:20 A.M. At 9:36 A.M. State tested Nurse Aide (STNA) #113 entered the room. Resident #113 stated she had an incontinent episode and needed her brief changed. STNA #113 deactivated the call light, collected the breakfast tray, and stated the aide on the hall would return to change the resident's brief. At 10:32 A.M. Resident #61 reactivated her call light. At 10:33 A.M. STNA #223 and STNA #113 answered the light, and STNA #223 provided incontinence care to Resident #61. During an interview on 07/01/24 at 10:39 A.M., STNA #113 verified Resident #61 had asked for incontinence care at 9:36 A.M. STNA #113 verified she did not return to Resident #61's room, and incontinence care was not provided until 10:33 A.M STNA #113 stated incontinence care was supposed to be provided every two hours and as needed. Review of the facility policy titled Routine Resident Care dated 03/07/23 revealed incontinence care will be provided timely according to each resident's needs. This deficiency represents noncompliance investigated under Complaint Number OH00155306 and Complaint Number OH00154306.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on medical record review, staff interviews, and policy review, the facility failed to ensure residents were free of any significant medication errors when the residents did not receive their medications as physician ordered when the electronic record was not available. This affected five (Residents #12, #13, #17, #26, and #61) of five residents reviewed for medication administration. The facility census was 87. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included stage III chronic kidney disease, type II diabetes mellitus, and vascular disease. Review of Resident #12's physician orders revealed medications included SymlinPen 120 subcutaneous pen-injector 2,700 microgram (mcg) per 2.7 milliliter (ml) -inject 120 mcg subcutaneously with meals and Humalog Insulin 100 units per ml - inject subcutaneously as per sliding scale before meals. Review of the Medication Administration Record (MAR) dated June 2024 revealed Resident #12 had no documentation for blood glucose monitoring and medication administration on 06/09/24 for medications including SymlinPen 120 mcg at 12:00 P.M. and 5:00 P.M. and Humalog insulin per sliding scale at 12:00 P. M. and 5:00 P.M. During an interview on 06/27/24 at 11:13 A.M., the Director of Nursing (DON) stated on 06/09/24, she was notified of the internet not working around noon. She started making telephone calls to the internet provider and the Information Technology (IT) department. Her understanding was that nurses were using their hot spot on their personal phones to gain internet access to use point click care (the facility's electronic medical record) and was unaware of any disruption to medication administration. The DON stated the back-up plan included that receptionist printed MARs and Treatment Administration Records (TAR) for every resident in the building every weekend to be used in case of a power outage. The records were stored in a black box at the receptionist's desk. The DON verified Residents #12 did not receive SymlinPen 120 mcg at 12:00 P.M. and 5:00 P.M. and Humalog insulin per sliding scale at 12:00 P.M. and 5:00 P.M. on 06/09/24. 2. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included stage III chronic kidney disease and diabetes mellitus. Review of Resident #13's physician orders revealed an order for Lispro insulin 100 units per ml as per sliding scale before meals and at bedtime. Review of the MAR dated June 2024 revealed Resident #13 had no documentation on 06/09/24 of blood glucose monitoring or Lispro insulin administration at 12:00 P.M. or 5:00 P.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Laurels of Kettering		STREET ADDRESS, CITY, STATE, ZIP CODE 694 Isaac Prugh Way Kettering, OH 45429	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/27/24 at 11:13 A.M., the DON stated on 06/09/24 she was notified of the internet not working around noon. She started making telephone calls to the internet provider and the IT department. Her understanding was that nurses were using their hot spot on their personal phones to gain internet access to use point click care (the facility's electronic medical record) and was unaware of any disruption to medication administration. The DON stated the back-up plan included that receptionist printed MARs and TAR for every resident in the building every weekend to be used in case of a power outage. The records were stored in a black box at the receptionist's desk. The DON verified Residents #13 did not have blood glucose monitoring or Lispro insulin administration at 12:00 P.M. or 5:00 P.M. on 06/09/24. 3. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus (DM) and dependence on renal dialysis. Review of Resident #20's physician orders dated 05/08/24 revealed an order for Insulin Lispro (one unit dial) subcutaneous solution pen-injector 100 units/ml: Inject as per sliding scale subcutaneously before meals and at bedtime for DM. Review of the MAR dated 06/09/24 revealed Resident #20 had no documentation for blood glucose monitoring or insulin administration on 06/09/24 at 7:30 A.M., 11:30 A.M., or 5:30 P.M. During an interview on 06/27/24 at 11:13 A.M., the DON stated on 06/09/24 she was notified of the internet not working around noon. She started making telephone calls to the internet provider and the IT department. Her understanding was that nurses were using their hot spot on their personal phones to gain internet access to use point click care (the facility's electronic medical record) and was unaware of any disruption to medication administration. The DON stated the back-up plan included that receptionist printed MARs and TAR for every resident in the building every weekend to be used in case of a power outage. The records were stored in a black box at the receptionist's desk. The DON verified Residents #20 did not have blood glucose monitoring or insulin administration on 06/09/24 at 7:30 A.M., 11:30 A.M., or 5:30 P.M. 4. Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus (DM). Review of Resident #26's physician orders for Humalog KwikPen subcutaneous solution pen-injector 100 unit/ml (Insulin Lispro); Inject as per sliding scale subcutaneously before meals and at bedtime, Enoxaparin Sodium Solution 30 mg/0.3 ml: Inject 30 mg subcutaneously every 12 hours for prevent blood clotting, and Lantus SoloStar subcutaneous solution pen injector 100 units/ml (Insulin Glargine) Inject 15 unit subcutaneously one time a day for DM. Review of the MAR dated June 2024 revealed on 06/09/24, Resident #26 had no documentation for blood glucose monitoring or Lispro Insulin administration at 7:30 A.M., 11:30 A.M. or 4:30 P.M., Glargine insulin administration at 9:00 A.M., or Enoxaparin administration at 8:00 A.M. (continued on next page)

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The Laurels of Kettering	694 Isaac Prugh Way Kettering, OH 45429

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/27/24 at 11:13 A.M., the DON stated on 06/09/24 she was notified of the internet not working around noon. She started making telephone calls to the internet provider and the IT department. Her understanding was that nurses were using their hot spot on their personal phones to gain internet access to use point click care (the facility's electronic medical record) and was unaware of any disruption to medication administration. The DON stated the back-up plan included that receptionist printed MARs and TAR for every resident in the building every weekend to be used in case of a power outage. The records were stored in a black box at the receptionist's desk. The DON verified Residents #26 did not have blood glucose monitoring or Lispro Insulin administration at 7:30 A.M., 11:30 A.M. or 4:30 P.M., Glargine insulin administration at 9:00 A.M., or Enoxaparin administration at 8:00 A.M. on 06/09/24. 5. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus and stage III chronic kidney disease. Review of Resident #61's physician orders revealed an order for Lispro Insulin 100 units per ml as per sliding scale before meals and at bedtime Review of MAR date June 2024 revealed on 06/09/24, Resident #61 had no documentation of blood glucose monitoring or Lispro insulin administration at 12:00 P.M. or 5:00 P.M. During an interview on 06/26/24 at 9:53 A.M., Licensed Practical Nurse (LPN) #187 stated on 06/09/24, the internet went down. The backup MARs at the reception desk were not up to date, so she did not give medications to the residents on 06/09/24 from approximately 10:00 A.M. to 6:20 P.M. while the connection was disrupted. During an interview on 06/27/24 at 11:13 A.M., the DON stated on 06/09/24 she was notified of the internet not working around noon. She started making telephone calls to the internet provider and the IT department. Her understanding was that nurses were using their hot spot on their personal phones to gain internet access to use point click care (the facility's electronic medical record) and was unaware of any disruption to medication administration. The DON stated the back-up plan included that receptionist printed MARs and TAR for every resident in the building every weekend to be used in case of a power outage. The records were stored in a black box at the receptionist's desk. The DON verified Residents #61 did not have blood glucose monitoring or Lispro insulin administration at 12:00 P.M. or 5:00 P.M. on 06/09/24. During an interview on 06/27/24 at 12:07 P.M., Receptionist #207 stated she had worked the previous weekend and did not print the back-up order summaries or face sheets due to the facility was out of paper. The receptionist verified the backup documentation currently available was outdated and would not be updated until the following weekend. Review of the policy titled Medication Administration dated 10/17/23 revealed medications will be administered according to written physician's orders in an accurate, safe, timely, and sanitary manner. Review of the policy titled Electronic Medical Record: Disaster Plan dated 01/31/22 revealed in the event of a power outage or disruption of internet services, paper forms of medication and treatment administration records were made available to document the delivery of care and were attached to the resident's electronic medical record once the electronic medical record became available. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents noncompliance investigated under Complaint Number OH00154306.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on staff interview, record review, and policy review, the facility failed to ensure the resident's medication administration records (MAR) and treatment administration records (TAR) were available during disruption of internet services. This affected five (Residents #12, #13, #20, #26, and #61) of five residents reviewed for medical records and the potential to affect all 87 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE]. Resident #12 had physician orders for medications and treatments on 06/09/24. Review of the MAR and TAR dated June 2024 revealed Resident #12 had no documentation for blood glucose monitoring and medication administration on 06/09/24 for medications including SymlinPen (insulin) at 12:00 P.M. and 5:00 P.M., Lactobacillus (probiotic) at 5:00 P.M., Humalog insulin per sliding scale at 12:00 P.M. and 5:00 P.M., Hydralazine (treats high blood pressure) at 3:00 P.M., and Gabapentin (treats nerve pain) at 12:00 P.M. and 5:00 P.M. Additional review revealed no documentation on 06/09/24 for Sugar Free Health Shake (a high calorie nutritional supplement) at 1:00 P.M., for day shift application of Paste Base Paste topically to buttocks, or day shift monitoring of vital signs, side effects to psychoactive medications, or signs/symptoms of hypo/hyperglycemia. 2. Review of the medical record for Resident #13 revealed an admitted [DATE]. Resident #13 had physician orders for medications and treatments on 06/09/24. Review of the MAR and TAR dated June 2024 revealed Resident #13 had no documentation on 06/09/24 of blood glucose monitoring or Lispro insulin administration at 12:00 P.M. or 5:00 PM and Furosemide (diuretic) at 5:00 P.M. Additional review revealed Resident #13 had no documentation on 06/09/24 for day shift treatments or monitoring including Santyl ointment application to sacrum, Med Pass (nutritional supplement) administration at 3:00 P.M., and daily weight. 3. Review of the medical record for Resident #20 revealed an admitted [DATE]. Resident #20 had physician orders for medications on 06/09/24. Review of the MAR dated 06/09/24 revealed Resident #20 had no documentation for blood glucose monitoring or insulin administration on 06/09/24 at 7:30 A.M., 11:30 A.M., or 5:30 P.M. 4. Review of the medical record for Resident #26 revealed an admitted [DATE]. Resident #26 had physician orders for medications and treatments on 06/09/24. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the MAR and TAR dated June 2024 revealed on 06/09/24 Resident #26 had no documentation for blood glucose monitoring or Lispro Insulin administration at 7:30 A.M., 11:30 A.M. or 4:30 PM, Glargine insulin administration at 9:00 A.M., or Enoxaparin (prevents blood clots) administration at 8:00 A.M. Additionally, on 06/09/24 Resident #26 had no documentation for day shift enteral feeding orders including, stopping Glucerna Tube feeding at 8:00 A.M., starting Glucerna tube feeding at 2:00 P.M., checking residual, checking placement, or 240 millimeters of water flushes at 9:00 A.M., 1:00 P.M., and 5:00 P.M. 5. Review of the medical record for Resident #61 revealed an admitted [DATE]. Resident #61 had physician orders for medications on 06/09/24. Review of the MAR dated June 2024 revealed on 06/09/24 , Resident #61 had no documentation of blood glucose monitoring or Lispro insulin administration at 12:00 P.M. or 5:00 P.M., Gemfibrozil (lowers triglycerides) at 5:00 P.M., and Gabapentin (treats nerve pain) at 3:00 P.M. During an interview on 06/26/24 at 9:53 A.M., Licensed Practical Nurse (LPN) #187 stated on 06/09/224, the internet went down. The backup MARs and TARs were at the reception desk and were not up to date, so she did not administer medications to the residents on 06/09/24 from approximately 10:00 A.M. to 6:20 P.M. while the connection was disrupted. During an interview on 06/27/24 at 11:13 A.M., the Director of Nursing (DON) stated on 06/09/24 she was notified of the internet not working around noon. She started making telephone calls to the internet provider and the Information Technology (IT) department. Her understanding was that nurses were using their Hot spot on their personal phones to gain internet access to use point click care (electronic medical record) and was unaware of any disruption to medication and treatment administrations. The DON stated the back-up plan included that receptionist printed the MARs and TARs for every resident in the building every weekend to be used in case of a power outage. The records were stored in a black box at the receptionist's desk. The DON verified medical records for Residents #12, #13, #20, #26, and #61 showed no documentation for multiple medications and treatments not completed. During an interview on 06/27/24 at 12:07 P.M., Receptionist #207 stated she had worked the previous weekend and did not print the back-up order summaries or face sheets due to the facility being out of paper. The receptionist verified the backup documentation currently available was outdated and would not be updated until the following weekend. Review of the policy titled Electronic Medical Record: Disaster Plan dated 01/31/22 revealed in the event of a power outage or disruption of internet services, paper forms of medication and treatment administration records were made available to document the delivery of care and were attached to the resident's electronic medical record once the electronic medical record became available. This deficiency represents noncompliance investigated under Complaint Number OH00154306.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observations, staff interviews, medical record review, and policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for residents with chronic wounds and/or indwelling medical devices. This affected 11 (Residents #13, #18, #20, #23, #24, #25, #30, #36, #79, #82, and #88) of 23 residents reviewed for EBP. The facility census was 87. Findings include: 1. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included acute respiratory failure with hypoxia and stage III chronic kidney disease. Review of the wound progress note dated 06/06/24 revealed Resident #13 had a Stage IV pressure ulcer (Full thickness tissue loss with exposed boned, tendon or muscle) to the sacrum. Review of the physician order summary dated 06/27/24 revealed Resident #13 had no physician orders for EBP related to chronic wounds. Observations on 06/27/24 at 9:24 A.M. revealed Resident #13 did not have appropriate, visible signs for EBP posted outside of their room. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #13 did not have orders for EBP and should have them in place because the resident had a chronic wound. 2. Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included bilateral deep vein thrombosis and unstageable pressure ulcer (slough and/or eschar: known but not stageable due to cover of wound bed by slough and/or eschar) to unspecified site. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 had one unstageable ulcer due to coverage of wound bed by slough that was present upon admission. Review of the physician order summary dated 06/26/24 revealed Resident #18 had no physician orders for EBP related to chronic wounds. Observations on 06/27/24 at 9:24 A.M. revealed Resident #18 did not have appropriate, visible signs for EBP posted outside of their room. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #18 did not have orders for EBP and should have them in place because the resident had a chronic wound. 3. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included diastolic heart failure and dependence on renal dialysis. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had two unstageable deep tissue injuries present upon admission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician order summary dated 06/27/24 revealed Resident #20 had no physician orders for EBP related to chronic wounds. Observations on 06/27/24 at 9:24 A.M. revealed Resident #20 did not have appropriate, visible signs for EBP posted outside of their room. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #20 did not have orders for EBP and should have them in place because the resident had a chronic wound. 4. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 had one unstageable pressure injury (slough and/or eschar: known but not stageable due to cover of wound bed by slough and/or eschar) present upon admission Review of the physician order summary dated 06/26/24 revealed Resident #23 had no physician orders for EBP related to chronic wounds. Observations on 06/27/24 at 9:24 A.M. revealed Resident #23 did not have appropriate, visible signs for EBP posted outside of their room. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #23 did not have orders for EBP and should have them in place because the resident had a chronic wound. 5. Review of the medical record revealed Resident #24 was admitted to the facility on [DATE]. Diagnoses included disruption of external operation surgical wound and cirrhosis of the liver. Review of Resident #24's physician orders dated 06/24/24 revealed an order to monitor the right upper arms peripherally inserted central catheter (PICC) line for infection every shift. Resident #24 had physician orders dated 06/26/24 at 9:39 A.M. for EBP related to the PICC line. Observations on 06/26/24 from 9:13 A.M. to 9:37 A.M. revealed Resident #24 had no visible signs indicating EBP outside of their room. During an interview on 06/26/24 at 9:37 A.M., Licensed Practical Nurse (LPN) #187 verified Resident #24 had PICC line devices and did not have appropriate signs posted for EBP. 6. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE]. Diagnoses included malignant neoplasm of the liver, cellulitis of the left lower and right upper limb, and lymphedema. Review of the care plan dated 06/10/24 revealed Resident #25 was at risk for complications of intravenous (IV) therapy related to receiving IV medications related to abscess. Interventions included observing signs of infiltration at the access site. Review of the Nursing Comprehensive Evaluation dated 06/10/24 revealed Resident #25 had a peripherally inserted central catheter (PICC) line to the right upper arm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER The Laurels of Kettering		STREET ADDRESS, CITY, STATE, ZIP CODE 694 Isaac Prugh Way Kettering, OH 45429	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed Resident #25 did not have physician orders for EBP related to IV site until 06/26/24 at 9:23 A.M. Observations on 06/26/24 from 9:13 A.M. to 9:37 A.M. revealed Resident #25 had no visible signs indicating EBP outside of their room. During an interview on 06/26/24 at 9:37 A.M., Licensed Practical Nurse (LPN) #187 verified Resident #25 had PICC line devices and did not have appropriate signs posted for EBP. 7. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included cellulitis of the right lower limb and non-pressure chronic ulcer of the right foot with fat layer exposed. Review of the physician order summary dated 06/26/24 revealed Resident #30 had no physician orders for EBP related to chronic wounds. Observations on 06/27/24 at 9:24 A.M. revealed Resident #30 did not have appropriate, visible signs for EBP posted outside of their room. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #30 did not have orders for EBP and should have them in place because the resident had a chronic wound. 8. Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included displaced intertrochanteric fracture of the left femur and unspecified fall. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #36 had one unstageable pressure injury (slough and/or eschar: known but not stageable due to cover of wound bed by slough and/or eschar) present upon admission. Review of the order summary dated 06/27/24 revealed Resident #36 had no physician orders for EBP related to chronic wounds. Observations on 06/27/24 at 9:24 A.M. revealed Resident #36 did not have appropriate, visible signs for EBP posted outside of their room. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #36 did not have orders for EBP and should have them in place because the resident had a chronic wound. 9. Review of the medical record for Resident #79 revealed an admitted [DATE]. Diagnoses included dementia and Alzheimer's disease. Review of the wound progress note dated 06/27/24 revealed Resident #79 had a deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying soft tissue) to the left heel. Review of the medical record revealed Resident #79 had no physician orders for EBP related to chronic wounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER: The Laurels of Kettering		STREET ADDRESS, CITY, STATE, ZIP CODE: 694 Isaac Prugh Way Kettering, OH 45429	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 06/27/24 at 9:24 A.M. revealed Resident #79 did not have appropriate, visible signs for EBP posted outside of their room. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #79 did not have orders for EBP and should have them in place because the resident had a chronic wound. 10. Review of the medical record for Resident #82 revealed an admitted [DATE]. Diagnoses included atrial fibrillation. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #82 had a feeding tube. Review of the medical record revealed Resident #82 did not have physician order EBP related gastric feeding tube until 06/26/24 at 1:36 P.M. for EBP. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #82 did not have an order for EBP related to gastric feeding tube prior to the survey. 11. Review of the medical record for Resident #88 revealed an admitted [DATE]. Diagnoses included non-pressure chronic ulcer of the left heel. Review of the physician order summary dated 06/27/24 revealed Resident #88 had no physician orders for EBP related to chronic wound. Observations on 06/27/24 at 9:24 A.M. revealed Resident #88 did not have appropriate, visible signs for EBP posted outside of their room. During an interview on 06/27/24 at 12:44 P.M., the Director of Nursing (DON) verified Resident #88 did not have orders for EBP and should have them in place because the resident had a chronic wound. Review of the facility policy titled Enhanced Barrier Precautions (EBP) dated 04/01/24 revealed the facility used EBP in addition to standard precautions for residents with chronic wounds, indwelling medical devices, and infection or colonization with Multi Drug Resistant Organisms (MDROs). This deficiency represents noncompliance investigated under Complaint Number OH00154306.