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	09/19/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, staff interview, and policy review, the facility failed to notify resident representative of a resident's change in condition. This affected one (#33) resident out of three reviewed for changes in condition. The facility census was 63. Findings include: Review of the medical record for Resident #33 revealed an admitted [DATE] with medical diagnoses of left hemiparesis, congestive heart failure, diabetes mellitus, dementia, chronic obstructive pulmonary disease (COPD), and anemia. Review of the medical record for Resident #33 revealed an admission minimum data set (MDS) assessment, dated 08/12/24, which indicated Resident #33 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, bathing, bed mobility and transfers. No skin issues were noted on the MDS. Review of the medical record for Resident #33 revealed a physician order dated 08/07/24 to cleanse sacrum wound with soap and water, apply foam dressing, and change daily. Review of the medical record for Resident #33 revealed a wound/skin evaluation dated 08/06/24 which indicated Resident #33 had one new wound. The evaluation did not contain documentation to support the location, measurements, or description of the wound. Review of the medical record for Resident #33 revealed a wound/skin evaluation dated 09/12/24 which stated Resident #33 had a Stage II pressure ulcer to her sacrum which measured 1.0 centimeter (cm) by 0.6 cm with no depth noted. Review of the medical record revealed no documentation to support Resident #33 had a wound/skin evaluation done between 08/06/24 until 09/12/24. Review of the medical record for Resident #33 revealed no documentation to support Resident #33's representative was notified of the pressure ulcer. Interview on 09/18/24 at 2:49 P.M. with Director of Nursing (DON) confirmed the medical record for Resident #33 did not contain documentation to support the facility notified Resident #33's representative of the change of condition. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Notification of Change, revised 02/14/24 stated the facility must inform the resident, consult with the resident's practitioner, and notify, consistent with his/her authority, the resident representative when there is a change in status. The policy stated even when a resident is mentally competent, his or her designated resident representative or family, as appropriate, should be notified of significant changes in the resident's health status unless the resident does not want the notification. The policy stated a change in status would include: an accident involving the resident, a significant change in the resident's physical, mental, or psychosocial status, a need to significantly alter treatment, a decision to discharge or transfer the resident from the facility, and a change in room or roommate assignment. This deficiency represents non-compliance investigated under Complaint Number OH00157535.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure safe and orderly discharges. This affected two (#67 and #68) out of four residents reviewed for discharges. The facility census was 63. Findings include: 1. Review of the medical record for Resident #67 revealed an admitted [DATE] and a discharge date of [DATE]. Review of the medical record for Resident #67 revealed medical diagnoses of DM, hypertensive heart disease, and chronic obstructive pulmonary disease (COPD). Review of the medical record for Resident #67 revealed an admission minimum data set (MDS) assessment, dated 08/13/24, which indicated Resident #67 was cognitively intact and required substantial/maximum staff assistance for toilet hygiene, bathing, and transfers and required partial/moderate staff assistance for bed mobility. Review of the medical record for Resident #67 revealed a nurse progress note dated 09/04/24 at 8:30 A.M. that Resident #67 was sent to the emergency room for nausea and vomiting. Review of the medical record for Resident #67 revealed no documentation to support the facility completed a change of condition assessment or transfer form or that the information was provided to the hospital upon the residents transfer. 2. Review of the medical record for Resident #68 revealed an admitted [DATE] and a discharge date of [DATE]. Review of the medical record for Resident #68 revealed medical diagnoses of infection and inflammatory reaction due to internal joint prothesis, artificial knee joint, mechanical complication of internal left knee prothesis, anxiety, and hypertension. Review of the medical record for Resident #68 revealed an admission MDS assessment, dated 08/26/24, which indicated Resident #68 had severely impaired cognition and required partial/moderate assistance with toilet hygiene and bathing and substantial/maximum staff assistance with transfers. The MDS indicated Resident #68 was independent with bed mobility. Review of the medical record for Resident #68 revealed a change of condition assessment was completed on 09/04/24 which stated Resident #68 had a fall in the morning and was found unresponsive. The assessment stated Resident #68 was sent to the emergency room . Review of the medical record for Resident #68 revealed a facility transfer form had been completed. Further review of the medical record for Resident #68 revealed a hospital note dated 09/03/24 which stated the hospital called the nursing facility and asked the facility to fax Resident #68's Advanced Directive information to the hospital. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/18/24 at 2:40 P.M. with Director of Nursing (DON) confirmed the medical record for Resident #67 did not contain documentation to support the facility completed a transfer form for Resident #67's transfer to the hospital. DON confirmed the medical record for Resident #68 contained documentation to support the hospital had not received information regarding Resident #68's Advanced Directives. DON stated on 09/03/24 the facility's electronic health records (EHR) was down, and the staff were unable to print any medical information to send to the hospital. DON confirmed the medical record for Resident #70 did not contain documentation to support the facility staff completed a discharge recapitulation of stay or discharge summary for Resident #70's discharge. Review of the facility policy titled, Transfer and Discharge, revised 03/26/24 stated the transfer and dc process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility. The policy stated for emergency transfers to acute care the facility would obtain a physician order including the date of the transfers and the reason for the transfer. The policy stated a transfer form would be completed, a list of medications and a copy of the care plan goals would be sent to receiving hospital. The policy also stated the information provided to the receiving provider must include at a minimum, contact information of the practitioner responsible for care of the resident, resident representative information, Advanced Directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals and all other necessary information to meet the residents need including diagnoses, medications, recent labs, and resident status. The policy stated if the facility anticipates a discharge to community, a resident must have a discharge summary that included a recapitulation of stay, final summary of resident's health status at time of discharge, and reconciliation of pre-discharge medications with the resident's post dc medications. This deficiency represents non-compliance investigated under Complaint Number OH00157511 and Complaint Number OH00157535.

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure staff completed a recapitulation of a resident's stay upon discharge. This affected two (#66 and #70) out of four residents reviewed for discharges. The facility census was 63. Findings include: 1. Review of the medical record for Resident #66 revealed an admitted [DATE] and a discharge date of [DATE]. The medical record for Resident #66 revealed medical diagnoses of multiple myeloma, lumbar spinal stenosis, hypertensive heart disease, and diabetes mellitus (DM). Review of the medical record for Resident #66 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/03/24, which indicated Resident #66 was cognitively intact and was independent with bed mobility, toileting, transfers and eating. Review of the medical record for Resident #66 revealed no documentation to support the facility staff completed a discharge recapitulation of stay or discharge summary prior to Resident #66's discharge on 04/01/24. 2. Review of the medical record for Resident #70 revealed an admitted [DATE] and discharge date of [DATE]. The medical record for Resident #70 revealed medical diagnoses of Alzheimer's disease, hypertensive heart disease and urinary tract infection. Review of the medical record for Resident #70 revealed an admission MDS assessment, dated 08/28/24, which indicated Resident #70 had severely impaired cognition and was dependent upon staff for eating, toileting, bathing, and transfers and required substantial/maximum staff assistance for bed mobility. Review of the medical record for Resident #70 revealed a nurse progress note dated 09/12/24 at 4:21 P.M. which stated Resident #70 was discharged to another facility. Further review of the medical record for Resident #70 revealed no documentation to support the facility had completed a discharge recapitulation of stay or discharge summary. Interview on 09/18/24 at 2:40 P.M. with Director of Nursing (DON) confirmed the medical record for Resident #66 did not contain documentation to support the facility completed a discharge recapitulation of stay or discharge summary for Resident #66 discharge on 04/01/24. DON confirmed the medical record for Resident #70 did not contain documentation to support the facility staff completed a discharge recapitulation of stay or discharge summary for Resident #70's discharge. (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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Transfer and Discharge, revised 03/26/24 stated the transfer and dc process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility. The policy stated for emergency transfers to acute care the facility would obtain a physician order including the date of the transfers and the reason for the transfer. The policy stated a transfer form would be completed, a list of medications and a copy of the care plan goals would be sent to receiving hospital. The policy also stated the information provided to the receiving provider must include at a minimum, contact information of the practitioner responsible for care of the resident, resident representative information, Advanced Directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals and all other necessary information to meet the residents need including diagnoses, medications, recent labs, and resident status. The policy stated if the facility anticipates a discharge to community, a resident must have a discharge summary that included a recapitulation of stay, final summary of resident's health status at time of discharge, and reconciliation of pre-discharge medications with the resident's post dc medications. This deficiency represents non-compliance investigated under Complaint Number OH00157511 and Complaint Number OH00157535.

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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 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** 46613 Based on medical record review, staff interview, and policy review, the facility failed to properly assess a resident's skin breakdown at the time the area was first observed. Additionally, the facility failed to complete weekly monitoring of the wound and failed to complete treatments as ordered. This affected one (#33) out of three residents reviewed for wound care and services. The facility census was 63. Findings include: Review of the medical record for Resident #33 revealed an admitted [DATE] with medical diagnoses of left hemiparesis, congestive heart failure, diabetes mellitus, dementia, chronic obstructive pulmonary disease (COPD), and anemia. Review of the medical record for Resident #33 revealed an admission minimum data set (MDS) assessment, dated 08/12/24, which indicated Resident #33 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, bathing, bed mobility and transfers. No skin issues were noted on the MDS. Review of the medical record for Resident #33 revealed a physician order dated 08/07/24 to cleanse sacrum wound with soap and water, apply foam dressing, and change daily. Review of the medical record for Resident #33 revealed a wound/skin evaluation dated 08/06/24 which indicated Resident #33 had one new wound. The evaluation did not contain documentation to support the location, measurements, or description of the wound. Review of the medical record for Resident #33 revealed a wound/skin evaluation dated 09/12/24 which stated Resident #33 had a Stage II pressure ulcer to her sacrum which measured 1.0 centimeter (cm) by 0.6 cm with no depth noted. Review of the medical record revealed no documentation to support Resident #33 had a wound/skin evaluation done between 08/06/24 until 09/12/24. Review of the medical record for Resident #33 Treatment Administration Record (TAR) for August 2024 revealed no documentation to support the facility completed the treatment to the sacrum wound as ordered on 08/08/24, 08/14/24, and 08/19/24 through 08/30/24. Review of the September 2024 TAR revealed no documentation to support the facility completed treatment to Resident #33's sacrum wound on 09/02/24, 09/04/24, 09/08/24, and 09/14/24. Interview on 09/18/24 at 2:49 P.M. with Director of Nursing (DON) confirmed the medical record for Resident #33 did not contain documentation to support the wound assessment on 08/06/24 contained measurements, location of wound, or description of the wound. DON confirmed the medical record for Resident #33 did not contain documentation to support weekly wound assessments were completed or that Resident #33 received treatment to the sacral wound as ordered in August and September. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Skin Management, revised 08/14/24 stated the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. The policy stated residents admitted with any skin impairment would have appropriate interventions to promote healing, physician's order for treatment, and skin impairment location, measurements and characteristics documented. The policy stated the licensed nurse would initiate documentation in the electronic health record which included skin and wound evaluations for pressure injury and vascular ulcers and document weekly until area was resolved. This deficiency represents non-compliance investigated under Complaint Number OH00157535.