

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  06/16/2025
NAME OF PROVIDER OR SUPPLIER  The Laurels of Kettering		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record reviews, staff interviews, and policy reviews, the facility failed to complete a discharge summary or recapitulation of a resident's stay, failed to complete a bed hold notice when resident's were transferred to the hospital and failed to notify the Ombudsman of resident's discharges. This affected four (#15, #27, #75, and #134) out of four residents reviewed for discharges. The facility census was 76.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #134 revealed an admission date of 09/12/24 with medical diagnoses of chronic obstructive pulmonary disease, diabetes mellitus, hypertensive heart disease, and malignant neoplasm of kidney. Review of the medical record revealed a discharge date of 01/23/25.</p> <p>Review of the medical record for Resident #134 revealed a quarterly Minimum Data Set (MD'S) assessment, dated 12/20/24, which indicated Resident #134 was cognitively intact and was independent with activities of daily living.</p> <p>Review of the medical record for Resident #134 revealed a 72-hour care conference assessment which stated Resident #134 was undecided with discharge plans at this time and was homeless. The assessment stated Resident #134 stated she wanted to stay at the facility until he found housing or got a waiver to go to an Assisted Living.</p> <p>Review of the medical record for Resident #134 revealed a nurses' note, dated 11/25/24 at 12:41 P.M., which stated Resident #126 was issued a 30-day discharge notice due to nonpayment. The note stated Resident #126 verbalized he did not want his money to go to the facility as he had other bills such as storage and phone bill to pay monthly. Review of a Social Service (SS) note dated 01/20/25 at 4:11 P.M. which stated Social Service spoke with Resident #126 in regard to his discharge. The note stated Resident #134 stated he understood he would discharge to a hotel on 01/22/25. The note stated Resident #134 set up his own transportation along with the hotel booking. Review of the nurses' note, dated 01/22/25 at 6:44 P.M., stated Resident #134 discharged with his belongings, a copy of discharge summary, face sheet, and medication list.</p> <p>(continued on next page)</p>

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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the nurses' note dated 01/22/25 at 7:19 P.M. stated Resident #134 was unable to leave the facility due to his transportation never showed up and unable to go to the bank to get money for hotel. Further review revealed a Social Service note, dated 01/23/25 at 9:55 A.M. which stated Resident #134 discharged today to a hotel.</p> <p>Review of the medical record revealed a Discharge Notice for Non-payment, dated 11/25/24, which stated Resident #134 was to discharge to another nursing facility due to outstanding balance.</p> <p>Review of the medical record for Resident #134 revealed a Post Discharge Plan and Summary, dated 10/09/24 and signed as completed on 01/31/25. Further review of Resident #134's medical record revealed there was no documentation regarding a recapitulation of the residents stay.</p> <p>Review of the medical record for Resident #134 revealed no documentation to support the Ombudsman's office was notified his discharge.</p> <p>Interview on 06/11/25 at 2:19 A.M. with Registered Nurse (RN) #387 confirmed the facility opens the Post Discharge Plan and Summary assessment upon a new resident admission. RN #387 confirmed Resident #134's assessment was signed after his discharge from the facility on 01/31/25. RN #387 confirmed there was no documented recapitulation of Resident #134's stay at the time of the discharge.</p> <p>3. Review of medical record for Resident #15 revealed an admission date of 02/12/24 with a discharge date of 05/28/25. Diagnoses included end stage renal disease (ESRD), atrial fibrillation, and major depressive disorder.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require partial assistance with eating, dependent on toileting, bathing, dressing, and transfers.</p> <p>Review of the progress note dated 05/25/25 at 2:02 P.M. revealed Resident #15 was unresponsive, hypertensive, and hypoglycemic and was sent to the hospital for evaluation.</p> <p>Review of the email notification to the Ombudsman dated 06/10/25 revealed all discharges from January through June 2025 were sent on 06/10/25.</p> <p>Interview on 06/11/25 at 8:03 A.M. with the interim Administrator revealed the previous Administrator was notifying the Ombudsman of discharged residents. The interim Administrator revealed there was a miscommunication with herself and social services where the notification to the Ombudsman was not getting completed.</p> <p>4. Review of the medical record for Resident #75 revealed an admission date of 03/15/25 with a discharge date of 04/04/25. Diagnoses included type II diabetes mellitus (DM II), peripheral vascular disease (PVD), and depression.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 13. This resident was assessed to require independent with eating, setup with toileting, dependent with bathing, dressing, and transfers.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the progress note dated 04/04/25 at 4:33 P.M. revealed Resident #75's daughter called and stated an Uber would transport Resident #75 to the Veterans facility at 5:00 P.M. Resident #75 in agreement.</p> <p>Review of the email notification to the Ombudsman dated 06/10/25 revealed all discharges from January through June 2025 were sent on 06/10/25.</p> <p>Interview on 06/11/25 at 8:03 A.M. with the interim Administrator revealed the previous Administrator was notifying the Ombudsman of discharged residents. The interim Administrator revealed there was a miscommunication with herself and social services where the notification to the Ombudsman was not getting completed.</p> <p>Review of the facility policy titled, Transfer and Discharge, revised 04/22/25, stated the transfer and discharge process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility. The policy stated the criteria for transfer/discharge included the resident or representative failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident did not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his/her stay. The policy stated the notice of transfer/discharge must be made by the facility in writing at least 30 days before the resident was transferred or discharged and in a manner they understand. The policy stated exceptions to the 30-day requirement notice which must be made as soon as practicable before transfer or discharge. The policy stated that when an anticipated discharge is scheduled, the post-discharge plan of care and summary are developed prior to his/her discharge. The policy stated Social Services/designee reviews the plan with the resident and, with consent, the resident representative, at least 24 hours prior to discharge or as soon as practicable of the residents' discharge from the facility. When the facility anticipates discharge, a resident must have a discharge summary that includes a recapitulation of the resident's stay that includes, but was not limited to: 1) diagnoses, course of illness/treatment, therapy, and pertinent lab, radiology, and consultation results, 2) final summary of the resident's status, at the time of discharge, that is available for release to authorized personas and agencies, with the consent of the resident or resident representative, 3) reconciliation of all pre-discharged medications with the resident's post-discharge medications (both prescribed and over-the-counter), 4) post discharge plan of care and summary that was developed with the participate of the resident. The post discharge plan of care and summary must indicate where the individual plans to reside, an arrangement that has been made for the residents' follow-up care and any post-discharge medical and non-medical services. The policy also stated the transfer and discharge process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility. The transfer or discharge notice must contain the name, address, and telephone number of the office of the State of the Long-Term Care Ombudsman.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162817.</p> <p>2. Medical record review for Resident #27 revealed she was admitted to the facility on [DATE]. Her diagnoses included atrial fibrillation, cellulitis of left lower leg, essential primary hypertension, osteoporosis, hyperlipidemia, anemia, and edema.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 was cognitively intact. Resident #27 was dependent on staff for medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>She was independent with eating and required supervision with upper body dressing, personal hygiene. Resident #27 required maximum assistance with toilet use, bathing, and lower body dressing.</p> <p>Review of the progress notes for Resident #27 revealed she was discharged to the hospital on [DATE] and returned to the facility on [DATE] following a hospital stay. Nothing related to a bed hold notification was identified in the progress notes.</p> <p>Interview on 06/12/25 at 10:53 A.M. with the Business Office Manager (BOM) #357 confirmed the facility failed to provide Resident #27 a bed hold notice upon discharge to the hospital on [DATE].</p> <p>Review of the facility policy titled, Bed Hold Policy, dated 02/14/22, confirmed the facility will contact the Resident or Responsible party regarding a bed hold. The facility will document the bed hold offer and the Resident/Responsible Party decision of the bed hold in the Resident's medical record.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on medical record review, staff interview, and policy review, the facility failed to ensure medications were administered as ordered which resulted in a significant medication error. This affected one (#135) out of six residents reviewed for medication administration. The facility census was 76.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #135 revealed an admission date of 02/09/25 with medical diagnoses of encounter for other orthopedic aftercare, arthrodesis, left above the knee amputation, and aftercare following joint surgery. Review of the medical record revealed a discharge date of 03/11/25.</p> <p>Review of the medical record for Resident #135 revealed an admission Minimum Data Set (MDS) assessment, dated 02/15/25, which indicated Resident #135 was cognitively intact and required supervision with activities of daily living.</p> <p>Review of the medical record for Resident #135 revealed physician orders dated 02/09/25 for oxycodone 10 milligram (mg) one tablet by mouth six times per day and oxycodone 5 mg one tablet by mouth every six hours as needed (PRN).</p> <p>Review of the medical record for Resident #135 revealed the February 2025 Medication Administration Record (MAR) which revealed documentation Resident #135 received routine oxycodone as ordered on 02/22/25. Further review of the MAR revealed no documentation to support Resident #135 received oxycodone 5 mg PRN on 02/22/25.</p> <p>Review of the medical record for Resident #135 revealed a form titled, Controlled Drug Record which revealed documentation on 02/22/25 that Resident #135 received two tablets of oxycodone 10 mg at 10:00 A.M., 2:00 P.M., and 6:00 P.M. Further review of the form revealed documentation on 02/22/25 that Resident #135 received two tablets of oxycodone 5 mg at 10:00 A.M., 2:00 P.M., and 6:00 P.M.</p> <p>Interview on 06/11/25 at 3:00 P.M. with Director of Nursing (DON) confirmed Resident #135's Controlled Drug Record had documentation to support Resident #135 received the wrong doses of oxycodone 10 mg and 5 mg on 02/22/25. DON also confirmed Resident #135's February MAR had documentation to support the nurse administered one tablet, not two tablets, of oxycodone 10 mg at 10:00 A.M., 2:00 P.M., or 6:00 P.M. and no documentation to support oxycodone 5 mg tablet was administered on 02/22/25.</p> <p>Review of the facility policy titled, Medication Administration, revised 10/17/23, stated medications are 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 also stated the staff are to record the dose, route, and time of medication administration on the Medication Administration Record.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00163625 and OH00163227.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the medical record, observations, interviews, and policy review, the facility failed to maintain infection control measures during wound care and peri care. This affected three (#3, #35, and #67) of five reviewed for infection control. The facility census was 76.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #35 revealed an admission date of 06/15/24. Diagnoses included heart failure, dementia, delusional disorders, and anxiety disorder.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11. This resident was assessed to require supervision with eating, dependent with toileting, bathing, dressing, and transfers.</p> <p>Review of the care plan dated 02/01/25 revealed Resident #35 had an actual impaired skin integrity related to pressure injury stage three to the coccyx with excoriation noted to peri-area. Interventions included conduct skin assessment weekly and measure area and document characteristics, observe for signs of infection, enhanced barrier precautions (EBP), and report abnormal findings to physician, obtain labs as ordered, refer to dietician as needed, and treatments as ordered.</p> <p>Review of the physician order dated 03/27/25 revealed Resident #35 was ordered enhanced barrier precautions related to coccyx wound.</p> <p>Observation on 06/12/25 at 10:48 A.M. revealed wound care was completed on Resident #35 by Licensed Practical Nurse (LPN) #304 and LPN #361. LPN #304 and LPN #361 did not apply gown for EBP precautions during wound care.</p> <p>Observation on 06/12/25 at 10:50 A.M. revealed LPN #304 did not perform hand hygiene after removing soiled gloves from incontinence care and then completed wound care on Resident #35.</p> <p>Interview on 06/12/25 at 10:59 A.M. with LPN #361 verified she did not wear a gown to assist with wound care on Resident #35.</p> <p>Interview on 06/12/25 at 11:01 A.M. with LPN #304 verified she did not wear a gown during wound care on Resident #35. LPN #304 also verified she did not perform hand hygiene after removing soiled gloves after incontinence care and during wound care.</p> <p>2. Medical record review for Resident #03 revealed she was admitted to the facility on [DATE]. Her diagnoses included gastro-esophageal reflux disease (GERD), atrial fibrillation, borderline personality disorder, osteoarthritis of knee, congestive heart failure (CHF), anemia, edema, major depressive disorder, and obstructive sleep apnea.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Minimum Data Set (MDS) assessment, dated 05/08/25, revealed Resident #03 was cognitively impaired. Resident #03 was dependent on staff for medication administration, lower body dressing, and transfers. She was independent with eating, Resident #03 required set up assistance with oral hygiene, and maximum assistance from staff with toilet use. She required moderate assistance from staff with showers, and personal hygiene. She was at risk for pressure ulcers. Resident #03 was marked for having zero pressure ulcers.</p> <p>Review of the physician orders for Resident #23 revealed no order related to enhanced barrier precautions.</p> <p>Review of the Treatment Administration Record for June 2025 for Resident #03 revealed no order for Enhanced Barrier Precaution.</p> <p>Review of the report titled, Skin and Wound Evaluation, dated 06/10/25, revealed Resident #03 had a pressure wound at a stage III that was acquired in house.</p> <p>Review of the facility report titled, Activity of Daily Living Task, for May 2025 revealed a reddened area was identified on 05/10/25 at the time of Resident #03's shower.</p> <p>Review of the wound note from the Wound Physician Assistant (WPA) #502 for Resident #03, dated 05/20/25, revealed the right buttock has a deep tissue injury persistent non blanchable deep red, maroon, or purple discoloration pressure ulcer that has received a status of not healed. The encounter measurements are 2 centimeter (cm) length x 3 cm width x 0.01 cm depth, with an area of 6 square (sq) cm and a volume of 0.6 cubic cm. The base of the wound bed has 51%-75%, bright pink, firm, granulation 1-25% slough. The diagnoses were listed as a pressure ulcer of right buttock, stage III. The plan of care was continued treatment and follow up in one to two weeks.</p> <p>Observation on 06/12/25 at 10:32 A.M. of Licensed Practical Nurse (LPN) #385 performed hand hygiene, however, she did not don a personal protective gown for Enhanced Barrier Precautions. Observed LPN #385 clean feces from Resident #03's backside with soap and water. Observed LPN #385 remove gloves and did not perform hand hygiene.</p> <p>Interview with LPN #385 on 06/12/25 at 10:59 A.M. and LPN # 322 confirmed she should have utilized proper personal protective equipment related to Resident #03's enhanced barrier precautions. LPN #322 confirmed she did not wash her hands after she completed per care.</p> <p>Review of the facility policy titled, Hand Hygiene, dated 05/08/25, confirmed hand hygiene should be performed before and after contact with the resident, after contact with blood, body fluids, visible contaminated surfaces, contact with objects in the resident's room, and after removing protective equipment, after use of restroom, and before meals. Staff involved in direct resident contact must perform hand hygiene (even if gloves are used).</p> <p>3. Medical record review for Resident #67 revealed she was admitted to the facility on [DATE]. Her diagnoses included acute kidney failure, cellulitis, essential primary hypertension, diabetes mellitus (DM), anemia, thrombocytopenia, and pressure ulcer of the sacral region.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS assessment for Resident #67, dated 05/13/25, revealed she was cognitively intact. Resident #67 was dependent on staff for medication administration. Resident #67 was moderately dependent on staff for oral hygiene, toilet use, personal hygiene, and dressing. Residents require supervision for eating and bathing. Resident #67 was marked at risk for pressure ulcers and had unhealed pressure ulcers that included a stage III pressure ulcer.</p> <p>Review of the TAR for Resident #67, dated June 2025, revealed no order for Enhanced Barrier Precaution.</p> <p>Review of the WPA #502 visit, dated 05/20/25, revealed Resident #67 was referred to WPA #502 after she was admitted to the facility with a stage III pressure ulcer on 05/13/25 revealed Resident #67 had a stage III pressure ulcer, and it has a status of not healed. Initial wound encounter was measured at 1.5 cm length x 2.0 cm width x 0.01 depth with an area of 3 sq cm and volume of .3 cubic cm. The wound bed has 1-25% bright red, pink, firm, granulation, 51-75% slough.</p> <p>Observation of wound care provided to Resident #67 on 06/12/25 at 11:26 A.M. revealed the facility failed to utilize proper personal protective equipment for enhanced barrier precautions by LPN #385 and Unit Manger (UM) #340.</p> <p>Interview with UM #340 confirmed they failed to don proper personal protective equipment for enhanced barrier precautions and failed to have proper notification on Resident #67's room related to enhanced barrier precaution.</p> <p>Review of the facility policy titled, Enhanced Barrier Precaution, dated 03/05/25, confirmed it is the intent of the facility to use Enhanced Barrier Precautions (EBP) in addition to Slandered Precautions for preventing the transmission of Centers for Disease Control targeted multi-resistant organisms (MDRO's). EBP is indicated for Residents with any of the following: infection or colonization with CDC-targeted MDRO, a wound, or an indwelling catheter medical device. Implementation included, post sign for precautions on the door or wall outside of the Resident's room that indicated type of precaution and required personal protective equipment (PPE).</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163625 and OH00163227.</p>		