

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  04/02/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record reviews, staff interviews, and policy review, the facility failed to complete comprehensive wound evaluations that included wound measurements or characteristics. This affected two (#09 and #85) residents out of the three residents reviewed for wound cares/services. The facility census was 81. Findings include: 1. Review of the medical record for Resident #09 revealed an admission date of 10/20/24 with medical diagnoses of atrial fibrillation, paranoid schizophrenia, and atherosclerotic heart disease (ASHD). Resident #09 readmitted to the facility on [DATE] with diagnosis of displaced intertrochanteric fracture of left femur status post surgical repair. Review of a quarterly Minimum Data Set (MDS) assessment, dated 01/31/26, revealed Resident #09 had moderate cognitive impairment and was independent with bed mobility and eating and required supervision with toilet hygiene, bathing, and transfers. Review of the Nursing Comprehensive Evaluation dated 03/10/26 revealed Resident #09 had a surgical incision to left lateral leg. The evaluation did not include measurements or wound description. Further review of the medical record revealed weekly skin assessment dated [DATE] which stated Resident #09 had surgical incision to hip, staples in place, and no measurements noted. Review of skin assessment dated [DATE] indicated Resident #09 had surgical incision to hip which was healing and no measurements were noted. Review of skin assessment dated [DATE] revealed Resident #09 had three small incisions to left hip, left medial thigh, and left medial above knee. The assessments stated the left knee incision had two small separate incisions which were measured as a cluster, steri-strips in place to all areas, covered with abdominal pad and secured with tape. The assessment indicated measurements for left lateral knee incision measured 3.4 centimeters (cm) by 0.1 cm, rear left thigh measured 4.5 cm by 0.1 cm, front left lateral knee measured 3.5 cm by 0.1 cm and the rear left trochanter 4.3 cm by 0.1 cm. 2. Review of the medical record for Resident #85 revealed an admission date of 03/11/26 with medical diagnoses of left artificial shoulder joint, polyarthritis, hyperlipidemia, hypertension, and ASHD. Review of the medical record revealed Resident #85 discharged on 03/30/26. Review of an admission MDS assessment, dated 03/16/26, revealed Resident #85 was cognitively intact and required supervision with toilet hygiene and independent with bed mobility and transfers. The MDS indicated Resident #85 had a surgical incision. Review a Comprehensive Nursing Evaluation, dated 03/12/26, indicated Resident #85 had left shoulder surgical site with non-removeable dressing in place. The evaluation did not include measurements or a description of the surgical site. Review of a physician order for Resident #85, dated 03/11/26, stated do not remove the clear dressing and to leave in place until follow up appointment. Review of the skin assessment dated [DATE] and 03/29/26 indicated Resident #85 had no skin issues. Review of the skin assessment dated [DATE] indicated Resident #85 had a surgical site to left shoulder but did not indicate measurements or wound description. Interview on 04/02/26 at 9:54 A.M. with Director of Nursing (DON) confirmed Resident #85 admitted with a clear dressing to the surgical site and verified the medical records for Residents #09 and #85 did not contain documentation the facility completed comprehensive wound assessments that included wound measurements or characteristics. Review of the facility policy titled, Skin Management, revised 01/28/26, stated residents with wounds and/or pressure injury and those at (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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>risk for skin compromise are identified, evaluated, and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. The policy stated upon admission all residents are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic medical record on the nursing comprehensive evaluation. The policy stated residents admitted with any skin impairment would have appropriate interventions implemented to promote healing, a physician's order for treatment, and skin impairment location, measurements, and characteristics documented. The policy continued to state the licensed nurse would initiate documentation in the electronic health record (EHR), which included a description of the skin impairment as followed: in EHR facilities, the licensed nurse would document on the skin issues evaluation any skin issues identified, document weekly until the area was resolved, and photos would be taken unless refused by the resident. This deficiency represents non-compliance investigated under Complaint Number 2966549.</p>