STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366396	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Athens, The	70 Columbus Circle Athens, OH 45701

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of shower schedules, resident interview, staff interview, and policy review, the facility failed to ensure residents that were dependent on staff for personal care received the assistance needed for scheduled showers. This affected one (Resident #66) of four residents reviewed for activities of daily living (ADL's). Findings include: Review of Resident #66's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included surgical aftercare following cardiovascular procedure, presence of coronary artery bypass graft, type II (adult onset) diabetes mellitus, morbid obesity, difficulty walking, muscle weakness, unspecified dementia with behavioral disturbances, bipolar disorder, chronic obstructive pulmonary disease (COPD) major depressive disorder, and congestive heart failure. Review of Resident #66's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a minimal difficulty with hearing and clear speech. She was able to make herself understood and was able to understand others. She was cognitively intact and was not known to have displayed any behaviors or reject care. She required partial/ moderate assist for showers/ bathing. Review of Resident #66's active care plans revealed the resident had a care plan in place for having a functional ability deficit and required assistance with self care related to fatigue/ weakness, impaired mobility, pain, shortness of breath, coronary artery disease (CAD) post coronary artery bypass graft (CABG), dementia, heart failure, and bipolar disorder. The goal was for the resident to improve or maintain her current level of function in shower/ baths. Interventions included attempting to use consistent routines as much as possible and encourage the resident to participate in self-care as much as able. Review of the shower schedule for the 100-400 halls revealed Resident #66 was scheduled to receive showers every Monday, Wednesday, and Friday. The shower was to be completed on day shift (7:00 A.M. to 7:00 P.M.). Review of Resident #66's shower/ bath documentation under the task tab of the electronic medical record (EMR) for the past 30 days (11/13/24-12/07/24) revealed staff documented a shower/ bath had been given by putting a Y in the box for yes, an N for no, or an R for refused. There was no documented evidence of the resident having been given a bath or a shower on 11/18/24 or on 11/25/25, both were scheduled shower days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 2:02 P.M., an initial interview with Resident #66 revealed she was supposed to get showers three times a week, but did not always get them. She reported some weeks she may only receive one or some weeks she may get two. She reported she would like to receive her showers in the morning before 10:30 A.M. On 12/10/24 at 4:05 P.M., a follow up interview with Resident #66 revealed she had not refused any showers when offered other than the shower she was scheduled to receive on 12/04/24. She indicated she only refused that shower as the staff had showered her the day before, which was not her scheduled shower day. She denied the staff even came in and asked her if she wanted a shower on 11/18/24 or 11/25/24. She had been told by the facility staff last week that her showers were scheduled every Monday, Thursday, and Saturday. She pointed out she had a reminder note on her bulletin board on the wall across from her bed that indicated she was a shower every Monday, Wednesday, and Saturday. On 12/10/24 at 4:09 P.M., the Director of Nursing (DON) acknowledged there was no documented evidence of Resident #66 receiving her scheduled shower on 11/18/24 or 11/25/24. She reported it was likely that the resident did not want one on those days, but she would look to see if they had any documentation to support why they were not given. On 12/10/24 at 4:40 P.M., an interview with the DON revealed Resident #66 was out of the facility for an appointment on 11/18/24. She claimed she had been told by a nurse that the resident was offered but refused a shower on that day. She reported it was documented in the nurses' progress notes. Further review of Resident #66's nurses' progress notes revealed the resident was documented as having been sent to an outside appointment on 11/18/24. The nurse's note revealed the resident was out of the facility at 11:08 A.M. and returned to the facility at 4:00 P.M. The nurses' progress notes did not indicate a shower had been offered and declined on that day, as was reported by the DON. There was nothing documented in the nurses' progress notes of any refusal for a shower offered on 11/25/24. On 12/10/24 at 4:55 P.M., a follow up with the DON confirmed the nurse's progress notes for 11/18/24 that documented Resident #66 going out and returning to the facility for an appointment did not provide evidence a shower had been offered and declined that day. She reported that was what the nurse had told her. She further confirmed there was no documented evidence of Resident #66 receiving or declining a shower on 11/25/24, when she was scheduled to receive one. Review of the facility's policy on Routine Resident Care revised 03/07/23 revealed it was the facility's policy for residents to receive the necessary assistance to maintain good grooming and personal hygiene. Showers were to be scheduled according to person centered care or state specific guidelines.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observation, medical record review, hospital record review, interviews and policy review the facility failed to ensure Resident #78 received timely, comprehensive and individualized care following a fall with injury. Actual harm occurred beginning on 12/02/24 at approximately 4:30 A.M. when Resident #78 experienced an unwitnessed fall with evidence of complaints of pain after the incident; however, the resident did not timely receive as needed pain medication until 8:44 A.M. or an x-ray of the area until 12/03/24 at 11:50 A.M. On 12/03/24 at 1:15 P.M. x-ray results revealed the resident had a displaced fracture of the left femoral head and was transferred to the hospital for surgical intervention. This affected one resident (#78) of two residents reviewed for falls. Findings include: Record review revealed Resident #78 admitted to the facility on [DATE] with diagnoses including dementia with mood disturbance, chronic kidney disease, mood disorder, depression, anxiety and history of transient ischemic attack and cerebral infarction without residual deficits. Review of the resident's medication orders revealed an order, dated 03/30/24 for Oxycodone tablet five milligrams (mg) one tablet by mouth every six hours as needed for pain, an order dated 11/25/24 for Tramadol 50 mg one tablet by mouth every six hours for pain, and an order dated 06/19/24 for Tylenol 325 mg two tablets by mouth three times a day for pain. Review of a care plan dated 05/06/24 revealed Resident #78 was at risk for pain related to constipation, back pain, gastro-esophageal reflux disease, osteoarthritis, kidney stones, fibromyalgia, and irritable bowel syndrome. Resident #78's goal was to have adequate relief or the ability to cope with incompletely relieved pain. Interventions included but were not limited to administer medications as ordered, evaluate characteristics of pain on a scale of zero through ten, evaluate the effectiveness of pain interventions as given, notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain, offer nonpharmacological interventions including massage, meditation, relaxation, ice pack, diversional activity, guided imagery, rest, and social interaction. An additional care plan dated 05/06/24 revealed Resident #78 required supervision or touching assistance to walk 50 feet with her walker. There were no behavior care plans developed for Resident #78. Review of a quarterly Minimum Data Set (MDS) completed on 10/25/24 revealed Resident #78 had impaired cognition, no behaviors, required supervision or touching assistance for bed mobility, transfers, and walking, and had zero falls. Review of a Risk Management report dated 12/02/24 at 4:30 A.M. revealed Resident #78 was found calling out for help and laying on her right side in the hallway with no observed injuries. Resident #78 stated she was looking for help. A full body assessment and neurological checks were completed. Range of motion was completed to all extremities and within normal limits, and it was unknown if the resident struck her head. The note included Resident #78 had a pain level of three. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing note dated 12/02/24 at 4:40 A.M. by Registered Nurse (RN) #324 revealed Certified Nursing Assistants (CNA's) reported hearing Resident #78 yell out for help and found her outside her room in the hallway laying on her right side. Resident #78 stated she was looking for help. Provider was notified of the fall and family was made aware. Review of a Post Fall Evaluation dated 12/02/24 revealed Resident #78 was looking for help when she fell . Resident #78 was observed on the floor in the hallway, the fall was unwitnessed, she had grippy socks on, was dry, and was using assistive devices at the time of the fall. While laying down, Resident #78's blood pressure was 136/78 and while sitting it was 140/92. Prior to the fall, Resident #78 had last been observed at 4:00 A.M. (the evaluation did not include what the resident was doing at the time of the observation). An intervention was in place to remind Resident #78 to use call light for assistance. Resident #78's statement regarding the incident was, trying to find help. Review of RN #324's statement dated 12/02/24 revealed Resident #78 was found lying on her right side in the hallway outside of her room with no injuries observed, range of motion (ROM) intact, and new orders were given for x-rays. There was no evidence the facility obtained any additional staff statements related to the fall/incident as part of an investigation. Review of an order dated 12/02/24 revealed Resident #78 required a bilateral hip x-ray and pelvic x-ray with two views due to pain status post fall and the x-ray was to be portable related to physical limitations. Review of the medication administration record (MAR) for December 2024 revealed Resident #78 received her already scheduled pain medication, Tramadol 60 mg at 6:00 A.M. for a pain level of seven (on a scale of 0-10 with 10 being the worst pain the resident has ever experienced). Additionally, at 8:44 A.M., Resident #78 received Oxycodone-acetaminophen 5-352 for pain rated six on a 0-10 pain scale. Resident #78's pain was rated a six and the administration was marked as effective. There was no documented evidence of Resident #78 being offered non-pharmacologic pain interventions or an as needed pain medication at the time of the fall. Review of a nursing note dated 12/02/24 at 3:35 P.M. by RN #312 revealed Resident #78 was resting in bed, no signs or symptoms of distress or new injuries from her previous fall, an x-ray was ordered (no indication identified), neurological checks were within normal limits, and she was safe with a call light and fluids in reach. Review of a nursing note dated 12/03/24 at 10:21 A.M. by RN #312 revealed Resident #78 was having no pain related to fall, neuro checks were within normal limits, and no distress was noted. Review of an interdisciplinary team (IDT) note dated 12/03/24 at 11:00 A.M. revealed the IDT met to discuss Resident #78's fall when she was found outside her room in the hallway on the floor lying on her right side. Resident #78 stated she was looking for help, her call light was not on, and no injuries were observed. Resident #78 complained of some pain at the time of the incident but denied pain after. An x-ray was ordered to be completed of bilateral hips. Visual cues were plated in her room at the time of the incident to remind her to use her call light to ask for assistance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing note dated 12/03/24 at 11:50 A.M. by RN #312 revealed a mobile x-ray company was in the facility to complete the ordered x-rays. Review of a nursing note dated 12/03/24 at 1:15 P.M. revealed the faxed x-ray results showed an acute displaced left femoral neck fracture. Resident #78 was in bed with a rolled-up bath blanket between her legs. Staff were made aware Resident #78 should not get out of bed and should be log rolled with care. The Unit Manager was made aware and left a message for the provider and a message was left with Resident #78's family. Review of a nursing note dated 12/03/24 at 1:50 P.M. by RN #312 revealed Resident #78's provider was aware of the x-ray results and gave a new order to send the resident to the emergency department. 911 was contacted for transport at 1:51 P.M. Review of a nursing note dated 12/03/24 at 2:27 P.M. revealed the ambulance was at the facility, a copy of the x-ray and report was given to Emergency Medical Technician (EMT) staff, and Resident #78 left the facility at 2:35 P.M. Review of a hospital note dated 12/06/24 revealed Resident #78 had presented to the hospital with complaints of left leg pain following a fall at her nursing home. Resident #78 was a poor historian and stated, I just need to lay down, I don't feel good. Details of the fall were unclear, and the resident's left lower extremity had good posterior tibial and pedal pulses, was pink and warm, and no deformity or shortening were noted. Resident #78 was mildly hypertensive which was likely pain related, and she required supplemental oxygen following the administration of narcotics. An x-ray of her left hip revealed a left femoral neck fracture which required surgery on 12/04/24 for fracture repair. On 12/09/24 at 9:47 A.M. Resident #78 was observed laying in her bed calling out for help stating, help me, God, I can't take this by myself, help me. Somebody please help me, I hurt so bad, help somebody, help please, I'm very sick and I can't get up. Resident #78 was wearing a hospital gown which was not tied in the back and as she was yelling out, Resident #78 was observed taking off her hospital gown. On 12/10/24 at 9:44 A.M. Resident #78 was again noted to be crying out for help. The resident was heard yelling Please, Lord, help me, I am sick. After approximately five minutes, a nurse ran down the hall to Resident #78's room and Resident #78 stated, My back is hurting and never stops. The nurse stated she would check in with Resident #78's nurse to see if medication was available. Review of a care plan dated 12/10/24 revealed Resident #78 had a fractured hip related to a fall. Interventions included but were not limited to activity as tolerated, change surgical incision dressings as ordered, encourage deep breathing and relaxation techniques, and anticipate and meet residents' needs. Interview on 12/11/24 at 8:29 A.M. with CNA #485 revealed she was told by the direct care staff (nursing assistants) who worked during Resident #78's fall, that when the nurse completed range of motion (ROM) to the resident's left leg, Resident #78 was screaming in pain, and the nurse did not address the pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 12/11/24 at 1:37 P.M. with RN #322 revealed following the fall on 12/02/24, Resident #78 was having minor pain, and did not walk or get up in the evening; she remained in bed. The RN revealed Resident #78 just kept saying her leg hurt but she would still roll over. RN #322 stated she would reposition the resident, provide distractions and low stimuli to help with pain. Interview on 12/11/24 at 1:44 P.M. with Anonymous Staff (AS) #512 revealed while working the night of 12/01/24 into the morning of 12/02/24, this staff person had assisted with Resident #78's care. AS #512 stated Resident #78 was saying it hurts so much, was tearful and upset and per AS #512's opinion likely had a broken hip because the resident had hollered and screamed out in pain. AS #512 stated he/she felt so bad for Resident #78 because when the nurse completed ROM, Resident #78 was screaming. The nurse was moving Resident #78's leg back and forth and the resident kept saying, stop, it hurts so much. AS #512 stated he/she told the nurse to call Resident #78's daughter about going to the hospital, but the nurse said she thought Resident #78 was fine, and family said she was dramatic. AS #512 stated Resident #78 could be dramatic, but staff should not assume a resident was not in pain. AS #512 stated staff could not move Resident #78 without her screaming, and they felt like they were torturing the resident. Resident #78 always had pain, but this was different, and she was walking prior to the fall, but was not able to after. AS #512 stated despite her and other staff's thoughts that Resident #78 needed to be sent out (to the hospital immediately after the fall), the nurse made the final call, and since they were not a nurse there was not anything else they could do. Interview on 12/11/24 at 2:10 P.M. with CNA #335 revealed the CNA had seen Resident #78 following the fall on 12/02/24. The CNA revealed Resident #78 was hysterical, crying, and saying continuously her hip was hurt. The CNA stated the nurse was aware Resident #78 was in pain, but stated her hip wasn't broken. Resident #78 was screaming bloody murder when the nurse completed ROM and told the nurse to stop because she was hurting. The nurse continued the ROM. Resident #78 kept saying, please stop, it hurts. CNA #335 stated staff did put a pillow under Resident #78 which helped a little, but she was really hurting so it was hard to change her. CNA #335 stated as soon as someone touched Resident #78's hip, she would start yelling and tense up. CNA #335 confirmed Resident #78 was able to walk prior to the fall, but after the fall, she was placed in the wheelchair, then taken to her bed. When Resident #78 was stood up, she screamed and did not walk the rest of the shift. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 12/11/24 at 2:18 P.M. with CNA #429 revealed Resident #78 was restless in the early morning of 12/02/24 and kept getting out of bed and walking down the hall. Resident #78 was very wobbly due to exhaustion. At approximately 4:30 A.M., CNA #429 heard Resident #78 yelling for help outside of her room. She was in the hallway, yelling and screaming, laying on her side, and there was no blood. CNA #429 stated the fall was unwitnessed but due to the way Resident #78 was laying, there were concerns her hip was injured but she stated she could not be sure. Resident #78 was yelling out in pain. The CNA revealed the resident did cry a lot and was dramatic, but stated this was different. CNA #429 stated every time someone would touch Resident #78's leg, she would let out a blood curdling scream and you could tell she was in pain and panicking. Resident #78 was in tears. The CNA stated Resident #78 waited on the floor for 15 minutes before the nurse came to assess her due to being on the other side of the building printing papers. When the nurse was assessing Resident #78, ROM was completed to her legs and that's when Resident #78 was letting out blood curdling screams. The nurse asked staff to get Resident #78 up, and staff helped the resident back to bed. CNA #429 stated no one attempted non-pharmacologic interventions. CNA #429 stated in their opinion, Resident #78 should have been sent out then because they had worked with someone who broke their hip before, and Resident #78's reactions reminded them of that instance. CNA #429 stated Resident #78 was able to walk prior to the fall, but would not bear weight after the fall, and was dead weight when staff transferred her to the bed. CNA #429 stated they were unsure of what the nurse's thoughts were as far as potential treatment due to lack of communication. Interview on 12/11/24 at 3 P.M. with the Director of Nursing (DON) confirmed Resident #78's blood pressure elevated when moved from laying down to a seated position, confirmed the lack of documentation in the nurse's notes, and stated her expectation if a resident had a fall resulting in hip pain would be for the nurse to call the physician to get a one-time order for pain medication and an order to send to the emergency department. The DON also stated staff should not move the resident. The DON acknowledged the x-ray was not ordered as soon as it should have been. Interview on 12/11/24 at 3:20 P.M. with CNA #346 revealed Resident #78 was confused and required a lot of redirections in the early morning of 12/02/24. CNA #346 was not present for the fall, but stated she did obtain the vitals cart and went to assist staff. CNA #346 stated she was a newer employee and although she did not know the residents yet, she could tell Resident #78 was in pain. CNA #346 stated the nurse did some assessments on Resident #78 and was really yanking on her poor hip. Resident #78 was screaming at the top of her lungs and the nurse told the resident nothing was broken. Resident #78 was asked to roll onto her back but stated she could not because her left leg really hurt. Resident #78 was placed in a wheelchair after being assessed and CNA #346 took her to the nurse's station but because there were no footrests on her wheelchair, when being pushed forward Resident #78's leg would get caught on the floor because she was unable to lift her leg, so she was taken down the hall in reverse. Once at the nurse's station CNA #346 stated she was able to tell how panicky the resident was, and knew something was wrong. Resident #78 was screaming and CNA #346 attempted to distract her by having her fold towels. CNA #346 was under the impression Resident #78 received Tylenol because nothing could be ordered at that time in the morning. Resident #78 was not able to bear weight when placed in bed, and staff had to hook their arms under Resident #78's arms to lift her out of the chair and place her into bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a statement dated 12/11/24 from CNA #349 revealed she went down the hall, the nurse was notified, vitals were taken, a pillow was placed under Resident #78's head, she was screaming, and she was assisted to bed. CNA #349 reported to the nurse Resident #78 never screams like that and she should call the resident's daughter. The nurse stated resident's daughter said Resident #78 was dramatic and it would be hard to tell if she was actually in pain. Resident #78 was screaming the whole time and more so when the nurse attempted ROM on her legs. Review of a statement dated 12/11/24 from RN #324 revealed she was on the south unit when an aide told her Resident #78 fell , they went to check on her and no deformities were noticed, no redness or skin issues. ROM was performed without issues, and Resident #78 was complaining about her knee but there was no redness or discoloration. Aides assisted Resident #78 into her wheelchair, she was taken up to the nurses' station, then decided to go to bed. Aides assisted Resident #78 back to bed and ROM was performed again without issues. Resident's daughter was notified and stated it would be hard to tell if she was in pain because she is so dramatic. Review of a statement dated 12/11/24 by CNA #346 revealed she had assisted with redirecting Resident #78 all night. The nurse came over to assess Resident #78 after an unwitnessed fall then assisted her into a wheelchair. Resident was assisted to the nurses' station, and CNA #346 does not know the residents well since she is new, but Resident #78 said it hurts so bad, but she is very confused and has dementia. Resident #78 was put back in bed. Review of an undated statement from RN #322 revealed Resident #78 reported to her around dinner time on 12/02/24 mild discomfort, non-pharmacologic interventions were attempted with some success, and scheduled pain medication was given with success. Review of an undated statement from RN #312 revealed Resident #78 stayed in bed for the whole shift per her routine and had complaints of pain in her back in the morning. Resident #78 was given as needed pain medication, and no other complaints were noted. Review of an undated statement from CNA #335 revealed she helped Resident #78 get back into bed after the fall and she witnessed the nurse perform ROM with the resident's legs. Resident #78 was tearful but baseline. On 12/12/24 at 7:45 A.M. during an interview with the Administrator, the Administrator requested the names of the staff the state surveyor had interviewed so she could now interview those staff as well. The Administrator verified she did not interview these CNAs who were working the night of the resident's fall and stated it was because she believed their interviews would not be taken into consideration because they were not nurses and were not able to ascertain if a resident was in pain and the nurse was qualified to make those types of judgement. The Administrator stated she believed the CNA staff would be inaccurate resources if interviewed because if they didn't like the nurse. The Administrator stated if there had been a need for a stat x-ray, Resident #78 would have just been sent to the hospital to ensure it was not delayed but stated to her knowledge there was no immediate need for an x-ray, and an in-house x-ray was completed. During the interview, the Administrator was informed interviews completed by the state surveyor were confidential but multiple staff who worked from 12/01/24 through 12/03/24 were interviewed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 12/12/24 at 1:21 P.M. with RN #324 revealed an aide came to the other side of the building to get her on the morning of 12/02/24 because a resident (#78) had fallen. She stated when she went to assess the resident, Resident #78 was laying in front of her room on the floor. Staff had put a pillow under her head. RN #324 stated she assessed the resident including ROM and everything was fine. RN #324 stated Resident #78 tended to be very dramatic about things, but her ROM was really good. During the assessment, Resident #78 yelled at RN #324 to stop bothering her and asked, why are you doing this? Resident #78 remained in bed the rest of the shift. RN #324 could not recall if an as needed medication was ordered, but stated if so, it would be documented in the MAR. Interview on 12/12/24 at 2:34 P.M. with Resident #78's daughter revealed she was called on 12/02/24 at about 7:00 A.M. and the night shift nurse informed her her mom had fallen. Resident #78's daughter stated the nurse told her everything was okay; Resident #78 just had some bruising but was not complaining of pain. The nurse did not tell the resident's daughter where the bruising was located. There was no offer to send the resident to the hospital for evaluation and the nurse stated Resident #78 was able to get up and into bed. Resident #78's daughter stated she came to visit her mom around 4:00 P.M. on 12/02/24 and her mom was dozing off but mentioned she was cold. The resident's daughter placed a sheet and blanket over her, and Resident #78 said oh no, that really hurts, you've got to take that off of me. The resident's daughter removed the blanket and left the sheet on the resident, and Resident #78 stated it hurt for the sheet to touch her as well. Resident #78 told her daughter her knee and hip were hurting. An aide came in and told Resident #78's daughter staff had trouble changing the resident earlier because of the pain and the resident had complained when staff put the sheet on her because the weight of the sheet on her hip was causing her pain which was why Resident #78 was cold and did not have a blanket on her initially. Shortly after, the nurse came in and administered the resident's scheduled Tramadol. The resident was not offered additional as needed or one-time dose of pain medication at that time. Resident #78's daughter stated her mom does yell out regularly when she needs something, but during the visit the resident was calling out for her dad to come help her with the pain, and this yelling out was worse than normal. The resident's daughter stated no staff had made her aware Resident #78 had pain with ROM, but staff did report when they attempted to roll her over, Resident #78 balled up a fist and tried swinging at them. Interview on 12/12/24 at 2:49 P.M. with Provider #522 revealed when notified of Resident #78's fall, the nurse reported a pain level of three which he stated was common for the resident. The resident's scheduled Tramadol was administered early that morning to also help with pain. The provider revealed no one reported increased pain after the initial call. Provider #522 stated if someone was calling out in pain, or with new pain, the doctor should be called. Provider #522 stated in this case, he was called and told interventions were effective. Provider #522 could not recall ordering an x-ray or why the x-ray was ordered. Interview on 12/12/24 at 2:53 P.M. with RN #324 revealed no staff working when Resident #78 fell expressed concerns to her that she could recall off the top of her head. Attempts to were made to contact RN #312 and CNA #334 and #348 during the investigation but no return calls were received. Review of a policy titled Notification of Change dated 02/14/24 revealed the facility must inform the resident, consult with the provider and the resident representative when there is a significant change in condition. A change in condition includes but is not limited to a need to alter treatment significantly. (continued on next page)

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	366396	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Athens, The	70 Columbus Circle Athens, OH 45701

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a policy titled Pain Management dated 04/11/23 revealed a comprehensive evaluation of pain includes history of pain and treatment; characteristics of pain; impact of pain on quality of life; factors such as activities, care or treatment that precipitate or exacerbate pain; factors that reduce pain' additional symptoms associated with pain' current medical conditions and medications; and the resident's goal for pain management and their satisfaction with current level of pain control. Resident will be monitored for the presence of pain and evaluated when there is a change in condition and whenever new pain, or an exacerbation of pain is suspected. Indicators of pain to observe for including moaning, crying and other vocalizations; wincing or frowning and other facial expressions; body posture such as guarding or protecting of an area of the body or lying very still; decrease in usual activities. In residents with dementia who cannot verbalize pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, striking out when moved or touched, and increased confusion. A CNA should communicate to a nurse when a resident is experiencing pain, and the nurse should communicate new onset of pain to the provider.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, and staff interview, the facility failed to ensure a resident with the use of supplemental oxygen had a physician's order for the use of oxygen and nebulizer equipment was properly cleaned/ stored when not in use. This affected one (Resident #210) of one residents reviewed for respiratory care. Findings include: Review of Resident #210's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses acute on chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), dependence on supplemental oxygen, and sleep apnea. Review of Resident #210's active care plans revealed the resident had a care plan in place for having a potential for difficulty breathing and risk for respiratory complications related to acute on chronic hypoxic respiratory failure, CHF, COPD, asthma, obstructive sleep apnea, oxygen dependence, and being a smoker. The goal was for the resident to display optimal breathing pattern daily and no labored breathing through the review date. The interventions included administering medication and treatments per physician orders. Review of Resident #210's physician's orders revealed she had an order in place to receive Ipratropium-Albuterol Solution (DuoNeb) 0.5-2.5 (3) Milligrams (mg)/3 milliliters (ml) with directions to inhale 3 ml orally four times a day for COPD. The order originated upon the resident's admission into the facility on [DATE]. The physician's orders did not include any order for the use of supplemental oxygen. Review of Resident #210's medication administration record (MAR's) for December 2024 revealed the resident was receiving her DuoNeb nebulizer aerosol treatments four times a day as ordered. The administration times were set up for 7:00 A.M., 12:00 P.M., 5:00 P.M., and 9:00 P.M. On 12/09/24 at 2:30 P.M., an observation of Resident #210 noted her to be in her room in bed. An oxygen concentrator was noted to be in her room next to her bed. The resident's nebulizer equipment was sitting on top of her dresser and was not stored in a bag when not in use. The resident reported she had used it twice that day. On 12/10/24 at 12:35 P.M., observation of Resident #210 noted her to be lying in bed on her left side. She was noted to be wearing oxygen per nasal cannula. Her nebulizer machine was off and lying on the bed next to her. The hand held mouth piece for the nebulizer was also lying in bed next to her. She was resting with her eyes closed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 10:20 A.M., an interview with RN #304 revealed Resident #2 did have the use of oxygen and wore it as needed. He checked the resident's physician's orders and verified the resident did not have an active order for the use of supplemental oxygen. He confirmed an order should be in place that directs them on what flow rate to administer. He was asked to accompany the surveyor to the resident's room and he verified she was wearing oxygen per nasal cannula at that time without a valid order. He further confirmed the resident's nebulizer equipment was not properly cleaned and stored between uses. He acknowledged the reservoir, where the medication was placed, still contained condensation and had not been rinsed or dried, after it's latest use. It was also found lying on top of the dresser next to her bed and not stored in a plastic bag, as it should be.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538 Based on observation, interview, and record review the facility failed to ensure residents with a diagnosis of dementia had a comprehensive and individualized treatment plan to ensure behaviors, including inappropriate dress when visible to others, were addressed to promote independence and dignity. This affected one resident (Resident #1) of one residents reviewed for dignity. The census was 101. Findings include: Review of Resident #1's medical record revealed an admitted [DATE], a reentry date of 01/25/22 and diagnoses including rheumatoid arthritis, unspecified convulsions, unspecified intellectual disabilities, dementia, hypothyroidism, and anemia. Review of Resident#1's annual Minimum Data Set (MDS) with an assessment reference date of 10/03/24 revealed a Brief Interview for Mental Status (BIMS) score of nine indicating the resident was moderately impaired. Further review of the MDS revealed Resident #1 required supervision or touching assistance with transfers from seated to standing and with ambulation during the look back period. Review of Resident #1's care plan did not reveal any interventions regarding the resident sitting in her room in view from the hallway, dressed in only a t-shirt and incontinence brief. Observations made of Resident #1 on 12/09/24 at 9:38 A.M., 12/10/24 at 10:00 A.M., 12/11/24 at 9:34 A.M. and on 12/12/24 at 9:20 A.M. revealed Resident #1 to be in her room, seated in a wheelchair next to the bed. Resident #1 was wearing only an incontinence brief and a t-shirt and could be fully viewed from the hallway. The resident was not interviewable and when staff would attempt to close the resident's door, the resident would repeat the word open until staff opened the resident's door. An interview on 12/11/24 at 9:46 A.M. with Certified Nursing Assistant (CNA) #419 revealed Resident #1 gets up and dresses herself in the morning before breakfast in a t-shirt and incontinence brief. Resident #1 usually eats her breakfast before putting on pants and will use her call light if she needs or desires assistance from staff. CNA #419 indicated Resident#1 would not allow them to close the door to her room and would not utilize a lap blanket. An interview on 12/11/24 at 1:00 P.M. with Licensed Practical Nurse (LPN) social services designee #386 revealed she was not aware of Resident #1's habit of being seated in her room and in view from the hallway, dressed in only a t-shirt and incontinence brief. An interview on 12/11/24 at 1:49 P.M. with Registered Nurse Unit Manager #315 verified Resident #1's care plan did not include interventions for the behavior of sitting in view from the hallway, dressed in only a t-shirt and incontinence brief. An interview on 12/12/24 at 9:20 A.M. with LPN social services designee (LPN/SSD) #386 verified Resident #1 was sitting in her room, in her wheelchair, dressed only in a t-shirt and incontinence brief and in full view from the hallway. LPN/SSD #386 verified this was not dignified for the resident or others in the facility due to her not wearing pants or being covered from the waist down.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 28923 Based on observation, review of meal tickets, review of menus/ spreadsheets to include special diets, and staff interview, the facility failed to ensure menus were followed for residents receiving consistent carbohydrate (CCHO) diets. This affected four residents (Resident #86, #88, #159, and #214) that were observed for tray preparation during tray line for the lunch meal served on 12/11/24. It had the potential to affect 31 other residents (Resident #4, #5, #6, #9, #10, #16, #17, #21, #22, #30, #34, #36, #39, #41, #44, #45, #51, #66, #68, #69, #73, #75, #80, #81, #82, #89, #101, #209, #210, #212, and #215) who were identified by the facility as being on a CCHO diet. Findings include: On 12/11/24 at 11:35 A.M., an observation of the tray line for the lunch meal served revealed dietary staff dipped the trays for the 900 hall first. The residents were receiving beef and noodle casserole, Normandy vegetables, one slice of bread of choice, and two chocolate chip cookies. Four residents (Resident #86, #88, #159, and #214) whose trays were dipped and loaded on the food cart for the 900 hall were noted to be on CCHO diets per their meal tickets. The meal tickets were being used to identify the residents' diets and were placed on the tray with the resident's plate with their food on it. A second dietary aide looked at the meal ticket when adding a slice of bread, the two cookies, and any condiments the resident had requested on the meal ticket. Resident #88, #159, and #214, who were three of the four on CCHO diets, were given two chocolate chip cookies as the other residents who were on regular diets. Resident #86 was not given two chocolate chip cookies, but was not given any other desserts as part of his lunch meal. Review of the cycle menu for Wednesday Week #3 revealed the CCHO diet for lunch called for the residents on that type of diet to be given beef and noodle casserole, Normandy vegetables, one slice of bread of the resident's choice, and four ounces of seasonal fresh fruit. They were not to have been given two chocolate chip cookies that the residents on regular diets were to receive. On 12/11/24 at 12:01 P.M., the 900 hall food cart arrived on the unit with the first tray passed at 12:02 P.M. A nurse and an aide were passing the trays. The meal trays contained the meal tickets that was used by the two staff members when passing trays to identify who they belonged to. The four residents (Resident #86, #88, #159, and #214) were clearly indicated on the meal ticket to be on a CCHO diet. The four residents were given their trays as was prepared by the dietary staff with Resident #88, #159, and #214 all receiving two chocolate chip cookies as included on their meal tray. Resident #86 was not given cookies or any other dessert and the staff passing the trays did not question what was on the trays being delivered. Findings were verified by RN #325 and Certified Nursing Assistant (CNA) #401. RN #325 acknowledged the residents on the 900 hall that were on a CCHO diet probably should not have been given cookies in place of the seasonal fresh fruit that was on the menu. She did not question what was on the tray and just provided it as was prepared by the dietary staff. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 12:26 P.M., an interview with Food Service Director #361 confirmed the tray observation for the 900 hall noted several residents who were identified as being on CCHO diets were given two chocolate chip cookies for their dessert when the CCHO diet menu indicated they should have received seasonal fresh fruit instead. He denied they had any seasonal fresh fruit prepared for the lunch meal service to give to those residents on a CCHO diet. He agreed the dietary staff should be serving the meals, as per the menu prepared by a dietician.