STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366457	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton Road Columbus, OH 43230

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, review of a facility abuse investigation, staff and resident interviews, and facility policy review, the facility failed to ensure one resident (Resident #26) was treated with dignity and respect. The deficient practice affected one resident (Resident #26) of three reviewed for dignity. The facility census was 96. Findings Include: Review of the medical record for Resident #26 revealed an admitted on 04/04/18. Medical diagnoses included paraplegia, chronic pain syndrome, need for assistance with personal care, and atherosclerotic heart disease of native coronary artery without chest pain. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #26 was independent with completing Activities of Daily Living (ADLs). Review of a facility investigation dated 06/24/24 revealed Resident #26 was involved in a consensual relationship with former Licensed Practical Nurse (LPN) #115. The relationship consisted of an exchange of inappropriate pictures and videos (some being sexual in nature) on two different private social media messaging applications. Resident #26 presented screen shots of text conversations with LPN #115 as well. Nude pictures and videos were sent back and forth between Resident #26 and LPN #115. Resident #26 stated LPN #115 had sent one nude picture of herself with the nurse's daughter present in the background. Resident #26 stated he told LPN #115 to delete the picture. Resident #26 stated the relationship began when LPN #115 worked as an aide at the facility. They became friends on the two social media sites and began talking to each other. Resident #26 stated he had requested the relationship slow down a couple weeks prior to the investigation because LPN #115 was visiting the resident's room too frequently. Resident #26 denied any physical contact had taken place between himself and LPN #115. Resident #26 stated LPN #115 slept in a chair in his room frequently while she was working. LPN #115 confirmed she had exchanged messages with Resident #26 via social media. LPN #115 initially denied sending any pictures or videos to Resident #26 but when informed Resident #26 had shown screen shots of the messages, pictures, and videos during the investigation, LPN #115 responded, Really?! He showed you? Well, I don't know then. LPN #115 was suspended following the interviews pending further investigation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366457	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton Road Columbus, OH 43230

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Employee Termination Report dated from 06/04/24 through 09/11/24 revealed LPN #115 was terminated on 07/08/24 for violating company policy. Interviews on 09/11/24 at 6:20 P.M., 09/12/24 at 10:48 A.M., and 09/12/24 at 3:22 P.M. with Resident #26 confirmed he had engaged in a relationship with former LPN #115 which included an exchange of messages, pictures, and videos on two different social media sites. Resident #26 confirmed the relationship was consensual and at times was sexual in nature. Resident #26 confirmed LPN #115 had sent nude pictures and videos to him since 05/17/24. Resident #26 stated there were approximately 25 messages and pictures and four videos sent to him from LPN #115. Resident #26 stated they had kissed once and exchanged several hugs. Resident #26 stated, we pretty much did everything except intercourse. Resident #26 confirmed LPN #115 would take naps in his room while she was working. Interview on 09/12/24 at 3:22 P.M. with the Administrator, Director of Nursing (DON) #176, and Assistant Director of Nursing (ADON) #141 confirmed LPN #115 and Resident #26 had engaged in an inappropriate relationship which consisted of an exchange of messages, pictures, and videos on two different social media sites. ADON #141 confirmed LPN #115 was terminated following the investigation for violating company policy related to the relationship. The administrative staff confirmed Resident #26 had not been treated with dignity and respect when LPN #115 sent Resident #26 inappropriate and at times sexually explicit pictures and videos. Review of the facility policy, Resident Dignity & Personal Privacy, dated 03/28/24, revealed the facility policy stated, care for residents in a manner that maintains dignity and individuality. Examine and treat residents in a manner that maintains their privacy. This deficiency represents non-compliance investigated under Complaint Numbers OH00156992 and OH00157368.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, review of a facility abuse investigation, resident and staff interviews, and facility policy review, the facility failed to report former Licensed Practical Nurse (LPN) #115 to the state Nursing Board for an inappropriate relationship with one resident (Resident #26). The deficient practice affected one resident (Resident #26) of three reviewed for abuse. The facility census was 96. Findings Include: Review of the medical record for Resident #26 revealed an admitted on 04/04/18. Medical diagnoses included paraplegia, chronic pain syndrome, need for assistance with personal care, and atherosclerotic heart disease of native coronary artery without chest pain. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #26 was independent with completing Activities of Daily Living (ADLs). Review of a facility investigation dated 06/24/24 revealed Resident #26 was involved in a consensual relationship with former Licensed Practical Nurse (LPN) #115. The relationship consisted of an exchange of inappropriate pictures and videos (some being sexual in nature) on two different private social media messaging applications. Resident #26 presented screen shots of text conversations with LPN #115 as well. Nude pictures and videos were sent back and forth between Resident #26 and LPN #115. Resident #26 stated LPN #115 had sent one nude picture of herself with the nurse's daughter present in the background. Resident #26 stated he told LPN #115 to delete the picture. Resident #26 stated the relationship began when LPN #115 worked as an aide at the facility. They became friends on the two social media sites and began talking to each other. Resident #26 stated he had requested the relationship slow down a couple weeks prior to the investigation because LPN #115 was visiting the resident's room too frequently. Resident #26 denied any physical contact had taken place between himself and LPN #115. Resident #26 stated LPN #115 slept in a chair in his room frequently while she was working. LPN #115 confirmed she had exchanged messages with Resident #26 via social media. LPN #115 initially denied sending any pictures or videos to Resident #26 but when informed Resident #26 had shown screen shots of the messages, pictures, and videos during the investigation, LPN #115 responded, Really?! He showed you? Well, I don't know then. LPN #115 was suspended following the interviews pending further investigation. There was no evidence LPN #115 had been reported to the State Board of Nursing following the completion of the investigation. Review of the Employee Termination Report dated from 06/04/24 through 09/11/24 revealed LPN #115 was terminated on 07/08/24 for violating company policy. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 09/11/24 at 6:20 P.M., 09/12/24 at 10:48 A.M., and 09/12/24 at 3:22 P.M. with Resident #26 confirmed he had engaged in a relationship with former LPN #115 which included an exchange of messages, pictures, and videos on two different social media sites. Resident #26 confirmed the relationship was consensual and at times was sexual in nature. Resident #26 confirmed LPN #115 had sent nude pictures and videos to him since 05/17/24. Resident #26 stated there were approximately 25 messages and pictures and four videos sent to him from LPN #115. Resident #26 stated they had kissed once and exchanged several hugs. Resident #26 stated, we pretty much did everything except intercourse. Resident #26 confirmed LPN #115 would take naps in his room while she was working. Observations on 09/12/24 at 10:48 A.M. of one picture and one video on Resident #26's cell phone revealed the picture was of LPN #115 in the facility, standing in an empty hallway, fully dressed in work scrubs. The video of LPN #115 was sexual in nature and included LPN #115 nude in a bathroom shower. Interview on 09/12/24 at 3:22 P.M. with the Administrator, Director of Nursing (DON) #176, and Assistant Director of Nursing (ADON) #141 confirmed LPN #115 and Resident #26 had engaged in an inappropriate relationship which consisted of an exchange of messages, pictures, and videos on two different social media sites. ADON #141 confirmed LPN #115 was terminated following the investigation for violating company policy related to the relationship. The administrative staff confirmed Resident #26 had not been treated with dignity and respect when LPN #115 sent Resident #26 inappropriate and at times sexually explicit pictures and videos. The administrative staff confirmed LPN #115 was not reported to the State Board of Nursing following the investigation. Review of the facility policy, Social Media/Networking, dated 06/01/24, revealed the policy stated, Be respectful. Be honest and accurate. Refrain from using social media while on work time or on equipment we provide. Review of the facility policy, Abuse Prohibition Policy, dated 10/14/22, revealed the policy stated, Nurses will be reported to the State Board of Nursing for violations that are substantiated. The facility has the obligation to report to state nurse aide registry or licensing authorities any knowledge it has of court actions against an employee that would make them unfit for service. This deficiency represents non-compliance investigated under Complaint Number OH00156992.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, review of a facility abuse investigation, resident and staff interviews, and facility policy review, the facility failed to complete a thorough investigation of an inappropriate relationship between former Licensed Practical Nurse (LPN) # 115 and one resident (Resident #26). The deficient practice affected one resident (Resident #26) of three reviewed for abuse. The facility census was 96. Findings Include: Review of the medical record for Resident #26 revealed an admitted on 04/04/18. Medical diagnoses included paraplegia, chronic pain syndrome, need for assistance with personal care, and atherosclerotic heart disease of native coronary artery without chest pain. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #26 was independent with completing Activities of Daily Living (ADLs). Review of a facility investigation dated 06/24/24 revealed Licensed Practical Nurse (LPN) #120 reported an allegation that former LPN #115 and Resident #26 were engaged in an inappropriate relationship. An interview with Resident #26 revealed he was involved in a consensual relationship with former LPN #115. The relationship consisted of an exchange of inappropriate pictures and videos (some being sexual in nature) on two different private social media messaging applications. Resident #26 presented screen shots of text conversations with LPN #115 as well. Nude pictures and videos were sent back and forth between Resident #26 and LPN #115. Resident #26 stated LPN #115 had sent one nude picture of herself with the nurse's daughter present in the background. Resident #26 stated he told LPN #115 to delete the picture. Resident #26 stated the relationship began when LPN #115 worked as an aide at the facility. They became friends on the two social media sites and began talking to each other. Resident #26 stated he had requested the relationship slow down a couple weeks prior to the investigation because LPN #115 was visiting the resident's room too frequently. Resident #26 denied any physical contact had taken place between himself and LPN #115. Resident #26 stated LPN #115 slept in a chair in his room frequently while she was working. LPN #115 confirmed she had exchanged messages with Resident #26 via social media. LPN #115 initially denied sending any pictures or videos to Resident #26 but when informed Resident #26 had shown screen shots of the messages, pictures, and videos during the investigation, LPN #115 responded, Really?! He showed you? Well, I don't know then. LPN #115 was suspended following the interviews pending further investigation. There was no evidence LPN #115 had been reported to the state Board of Nursing following the completion of the investigation. There was no evidence any additional residents or staff were interviewed to ensure no other residents had been affected. Review of the Employee Termination Report dated from 06/04/24 through 09/11/24 revealed LPN #115 was terminated on 07/08/24 for violating company policy. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 09/11/24 at 6:20 P.M., 09/12/24 at 10:48 A.M., and 09/12/24 at 3:22 P.M. with Resident #26 confirmed he had engaged in a relationship with former LPN #115 which included an exchange of messages, pictures, and videos on two different social media sites. Resident #26 confirmed the relationship was consensual and at times was sexual in nature. Resident #26 confirmed LPN #115 had sent nude pictures and videos to him since 05/17/24. Resident #26 stated there were approximately 25 messages and pictures and four videos sent to him from LPN #115. Resident #26 stated they had kissed once and exchanged several hugs. Resident #26 stated, we pretty much did everything except intercourse. Resident #26 confirmed LPN #115 would take naps in his room while she was working. Observations on 09/12/24 at 10:48 A.M. of one picture and one video on Resident #26's cell phone revealed the picture was of LPN #115 in the facility, standing in an empty hallway, fully dressed in work scrubs. The video of LPN #115 was sexual in nature and included LPN #115 nude in a bathroom shower. Interview on 09/12/24 at 3:22 P.M. with the Administrator, Director of Nursing (DON) #176, and Assistant Director of Nursing (ADON) #141 confirmed LPN #115 and Resident #26 had engaged in an inappropriate relationship which consisted of an exchange of messages, pictures, and videos on two different social media sites. ADON #141 confirmed LPN #115 was terminated following the investigation for violating company policy related to the relationship. The administrative staff confirmed Resident #26 had not been treated with dignity and respect when LPN #115 sent Resident #26 inappropriate and at times sexually explicit pictures and videos. The administrative staff confirmed LPN #115 was not reported to the state Board of Nursing following the investigation. The administrative staff confirmed no additional residents or staff had been interviewed to ensure no other residents were affected. Review of the facility policy, Social Media/Networking, dated 06/01/24, revealed the policy stated, Be respectful. Be honest and accurate. Refrain from using social media while on work time or on equipment we provide. Review of the facility policy, Abuse Prohibition Policy, dated 10/14/22, revealed the policy stated, The Administrator or Director of Nursing (DON)/designee shall initiate the Incident and Accident Investigation Form. The investigation may consist of: an interview with staff members having contact with the guest/resident during the period/shift of the alleged incident, interviews with the resident's roommate, family members, and visitor, interviews with any witnesses to the incident, and an interview with the person(s) reporting the incident. This deficiency represents non-compliance investigated under Complaint Number OH00156992.

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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 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** 41266 Based on record review, review of shower documentation, review of the shower schedule, resident and staff interviews, and facility policy review, the facility failed to ensure showers were completed as scheduled and per resident preference for two residents (Residents #69 and #79). The deficient practice affected two residents (Residents #69 and #79) of three residents reviewed for showers. The facility census was 96. Findings Include: Review of the medical record for Resident #69 revealed an admitted [DATE]. Medical diagnoses included cerebral infarction (stroke), multiple sclerosis, and muscle weakness. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #69 had intact cognition and scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #69 required substantial/maximal assistance with bathing or showering. Review of the care plan revised 04/22/24 revealed Resident #69 had a functional deficit and required assistance with self-care activities. Interventions included assistance with showering or bathing. Review of the shower schedule revealed Resident #69 was scheduled for a shower on Mondays and Thursdays during day shift. Observations and interviews on 09/16/24 at 12:36 P.M. and 09/17/24 at 11:36 A.M. and 1:57 P.M. with Resident #69 revealed the resident did not receive a shower or a bed bath as scheduled on 09/16/24. Resident #69 appeared to have scruffy facial hair on his face and was in a hospital gown during each observation. Resident #69 stated the assigned aide was not able to find the appropriate hoyer lift sling and pad in order to get the resident up out of bed and transfer the resident on to the shower table. Resident #69 stated he did not receive a bed bath either. Resident #69 stated he would like to receive a shower. Interview on 09/16/24 at 3:48 P.M. with State tested Nursing Assistant (STNA) #217 confirmed she had not been able to get Resident #69 out of bed yet today in order to provide a shower because she was not able to find the appropriate hoyer lift sling and pad to properly transfer the resident out of bed and on to the shower table. STNA #217 stated she was still trying to find it and if she was not able to she would provide the resident a bed bath instead of a shower. STNA #217 confirmed Resident #69 preferred to have showers. STNA #217 stated there was no way to differentiate whether a resident received a shower or a bed bath. The aide stated the documentation included both options but there was not an option to mark which one was received. Review of shower documentation from 09/05/24 through 09/16/24 revealed Resident #69 was marked as having a shower or bed bath on 09/16/24. Review of the Medication Administration Record (MAR) dated September 2024 revealed Registered Nurse (RN) #215 marked Resident #69's shower or bed bath as being received on 09/16/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/17/24 at 1:55 P.M. with RN #215 confirmed she had marked Resident #69's shower or bed bath as completed on 09/16/24. RN #215 stated the aide did not inform her of any showers or bed baths not being completed so she assumed the resident received a shower or bed bath as scheduled on 09/16/24. RN #215 stated she did not confirm with the aide whether or not all showers and bed baths had been provided prior to marking it as completed. RN #215 confirmed there was no way to differentiate whether a resident received a shower or a bed bath to her knowledge. Interview on 09/17/24 at 2:33 P.M. with the Director of Nursing (DON) #176 confirmed Resident #69 did not receive a shower or a bed bath yesterday, 09/16/24, as scheduled. DON #176 confirmed the resident preferred showers. DON #176 confirmed there was no documentation to differentiate whether a bed bath or a shower was provided to the residents per preferences. DON #176 stated she spoke with STNA #217 who confirmed she was not able to locate Resident #69's hoyer lift pad or sling in order to get the resident up out of bed and transfer him to the shower table. DON #176 confirmed RN #215 marked Resident #69's shower as completed on 09/16/24 but it had not been completed. 2. Review of the medical record for Resident #79 revealed an original admitted on 09/23/21 and a readmitted on 05/16/22. Medical diagnoses included dementia, hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left non-dominant side, adult failure to thrive, and acquired absence of right and left legs above the knee. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #79 had severely impaired cognition and scored three out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #79 required substantial/maximal assistance from staff to complete showering or bathing. Review of the care plan revised 09/12/24 revealed Resident #79 had a functional impairment and required staff assistance to complete Activities of Daily Living (ADLs). Interventions included Resident #79 required substantial assistance from the facility staff to complete bathing activity. Resident #79's bathing preference was shower/bed bath. Review of the shower schedule revealed Resident #79 was scheduled for showers on Mondays and Thursdays during day shift. Observations and interviews on 09/16/24 at 12:36 P.M. and 09/17/24 at 1:57 P.M. revealed Resident #79 appeared to have scruffy facial hair and greasy hair. Resident #79 denied he received a shower or a bed bath on Monday, 09/16/24 as scheduled. Resident #79 stated, I want a shower. Review of shower documentation dated from 09/05/24 through 09/16/24 revealed Resident #79 received a shower/bed bath on 09/16/24. Review of the Medication Administration Record (MAR) dated September 2024 revealed Registered Nurse (RN) #215 marked Resident #79's shower/bed bath as completed on 09/16/24. Interview on 09/16/24 at 3:48 P.M. with STNA #217 revealed Resident #79 had not received a bed bath or a shower yet today. STNA #217 stated she was running behind today. STNA #217 confirmed Resident #79 preferred showers. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/17/24 at 1:55 P.M. with RN #215 confirmed she had marked Resident #79's shower or bed bath as completed on 09/16/24. RN #215 stated the aide did not inform her of any showers or bed baths not being completed so she assumed the resident received a shower or bed bath as scheduled on 09/16/24. RN #215 stated she did not confirm with the aide whether or not all showers and bed baths had been provided prior to marking it as completed. RN #215 confirmed there was no way to differentiate whether a resident received a shower or a bed bath to her knowledge. Interview on 09/17/24 at 2:33 P.M. with the Director of Nursing (DON) #176 confirmed Resident #79 did not receive a shower or a bed bath yesterday, 09/16/24, as scheduled. DON #176 confirmed the resident preferred showers. DON #176 confirmed there was no documentation to differentiate whether a bed bath or a shower was provided to the residents per preferences. DON #176 stated she spoke with STNA #217 who confirmed she was running behind on completing showers yesterday, 09/16/24, and was not able to provide a shower or bed bath to Resident #79. DON #176 confirmed RN #215 marked Resident #79's shower or bed bath as completed on 09/16/24 but it had not been completed. Review of the facility policy, Activities of Daily Living (ADL) Program, dated 05/01/24, revealed the policy stated, Determine specific tasks and areas of Activities of Daily Living (ADLs) the resident requires restorative nursing assistance with including bathing and grooming. Document resident daily participation. This deficiency represents non-compliance investigated under Complaint Number OH00157368 and OH00156992.

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F 0698 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on closed record review, interview, and policy review the facility failed to ensure Resident #100, a newly admitted resident received hemodialysis services timely and as recommended by the hospital at the time of the resident's hospital discharge and failed to ensure timely and ongoing monitoring of the resident's hemodialysis access site for patency and/or signs of infection. This affected one resident (#100) of three residents reviewed for dialysis services. The facility census was 96. Actual harm occurred on 08/14/24 when the facility failed to ensure Resident #100 received hemodialysis treatments as ordered (between 08/10/24 and 08/14/24) resulting in an acute change in the resident's condition, including a swollen abdomen, generalized edema throughout the resident's body and presence of excessive fluid requiring transfer to the hospital for hemodialysis. The resident did not return to the facility after being transferred to the hospital. Findings include: Review of the closed medical record for Resident #100 revealed the resident was admitted to the facility on Saturday 08/10/24 with diagnoses including acute osteomyelitis, altered mental status, end stage renal disease, type two diabetes mellitus with hyperglycemia requiring long term use of insulin, ascites, hepatomegaly with splenomegaly and chronic kidney disease. Record review revealed the resident received hemodialysis. Review of hospital discharge record from the resident's hospitalization [DATE] to 08/10/24 revealed the resident was to follow up with dialysis services with a current dialysis schedule of Tuesday, Thursday, and Friday. Review of communication email dated 08/09/24 to the facility-based dialysis center admissions revealed Admissions Coordinator #170 notified the dialysis center the resident would be admitting on 08/10/24. The facility-based dialysis center performed dialysis treatments on Monday, Wednesday, and Fridays. Review of an admission assessment completed 08/10/24 revealed the resident was admitted due to osteomyelitis and was identified with dialysis access via arteriovenous (AV) shunt with a positive bruit and thrill. Review of the physician's orders with a start date of 08/13/24 (three days after admission) revealed liberal renal/cardiac consistent diet with double protein. There was also an order dated 08/12/24 (two days after admission) for staff to check bruit and thrill to left upper arm. And to observe fistula to left upper arm for thrombosis bleeding, stenosis, infection, steal syndrome and aneurysm. An additional order dated 08/12/24 (two days after admission included an order for the medication Velphoro (for chronic kidney disease). Lastly, an order dated 08/12/24 included the resident was to receive hemodialysis in house Monday, Wednesday and Friday. Review of the medication administration record (MAR) revealed Resident #100's fistula was first assessed beginning on 08/12/24 during night shift and continued until discharge on [DATE]. (continued on next page)

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	366457	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton Road Columbus, OH 43230

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F 0698 Level of Harm - Actual harm Residents Affected - Few	Review of a plan of care created on 08/12/24 revealed Resident #100 was at risk for complications related to the need for dialysis. A second plan of care revealed the resident was at nutritional and/or dehydration risk related to end-stage renal disease on hemodialysis. Neither care plan included any interventions. Review of an eINTERACT transfer form dated 08/14/24 revealed Resident #100 was exhibiting edema (new or worsening) of the abdomen. The form noted the resident had dialysis treatments on Monday, Wednesday, and Fridays and had a fistula to his left arm with provider recommendation to send to the hospital for evaluation. Review of a progress note dated 08/14/24 revealed Resident #100 ordered to be sent out to a local hospital for dialysis. Abdomen noted to be distended. Review of dialysis schedule for 08/12/24 and 08/14/24 revealed Resident #100 was not on the list to receive dialysis services on these dates. Review of 5-day Minimum Data Set (MDS) 3.0 assessment completed 08/28/24 revealed Resident #100 was cognitively intact and required assistance with activities of daily living. Interview on 09/30/24 at 11:06 A.M. with Admissions Coordinator #170 revealed an email was sent to the dialysis center informing the clinic of Resident #100's admission on 08/10/24; however, Admissions Coordinator #170 did not confirm with the clinic the resident had been admitted to the facility on [DATE]. Admission Coordinator #170 said the resident was marked as pending during the duration of his stay and due to the pending status, the resident was not placed on the dialysis schedule to receive dialysis treatment. Admissions Coordinator #170 revealed facility staff were expected to notify dialysis of new admissions to put them as active in the system. Interview on 09/30/24 at 11:19 A.M. with Licensed Practical Nurse (LPN) #268 revealed Resident #100 was admitted on [DATE] on her shift. Through review of the hospital record, it was identified the resident required dialysis services. LPN #268 informed the Director of Nursing (DON) who the LPN stated was responsible for dialysis admissions on the weekend, and did not hear an update back. LPN #268 confirmed she was responsible for putting in initial physician orders upon admission for residents to receive dialysis, LPN #268 confirmed she put in all admitting orders including the orders for dialysis on 08/10/12 and called the physician to verify. She did not see that the orders were verified by the physician by the end of her shift and she pass the information on to the oncoming nurse. The oncoming nurse was unable to be reached for interview by the surveyor. LPN #268 confirmed the next on-shift nurse was informed the resident was a dialysis patient. Interview on 09/30/24 at 2:33 P.M. with the DON denied working in the facility from 08/10/24 to 08/13/24. Upon her return (on 08/14/24), she stated she was informed Resident #100 had not received dialysis services as required and would require transfer to the hospital. The DON confirmed facility nursing staff should confirm with the dialysis clinic when a resident was physically in the building so they could remove them as pending in the dialysis system and add them to the schedule. The DON confirmed the resident did not receive two of his scheduled dialysis treatments, on 08/12/24 and 08/14/24 as per the order obtained on 08/12/24 for hemodialysis treatments every Monday, Wednesday and Friday. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/30/24 at 11:29 A.M. with the dialysis admissions coordinator revealed the clinic had been informed Resident #100 was planning on admitting to the facility on [DATE]. The Admissions coordinator denied facility staff followed-up to confirm the resident was actually admitted on [DATE] and required dialysis services to begin. Interview on 09/30/24 at 12:58 P.M. with the dialysis nurse revealed she was made aware on 08/14/24 Resident #100 had been admitted to the facility and did not receive scheduled dialysis treatment as ordered. Resident #100 was assessed by the dialysis nurse after notification and was found to have a swollen abdomen and generalized edema throughout his body. The dialysis nurse voiced Resident #100 did not look good due to the excessive fluid, and he would need to go to the hospital to receive dialysis treatment. The dialysis nurse said the resident was marked as pending in the system and facility staff did not notify the clinic he was admitted . Interview on 09/30/24 at 2:35 P.M. with the administrator confirmed the facility provided dialysis services on Monday, Wednesday and Friday when Resident #100 was admitted due to a low number of resident requiring dialysis services. Interview on 09/30/24 at 3:10 P.M. with Registered Nurse #143 revealed facility best practice for when a dialysis resident was admitted to the facility was to walk down to the clinic located in the facility and confirm with staff in-person and ask when the resident could receive treatment. Interview on 09/30/24 at 3:17 P.M. with Unit Manager #149 confirmed facility staff were required to confirm with the dialysis clinic that a resident had been admitted to the facility so they could remove the resident's pending status. Review of hemodialysis policy dated 09/26/23 revealed hemodialysis was a potentially life-saving procedure that removed blood from the body and circulated it through a purifying dialyzer, then returned the blood to the body. Staff were required to obtain a physician's order for hemodialysis upon admission. This deficiency represents non-compliance investigated under Complaint Number OH00156992 and Complaint Number OH00156955.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review, interview, and policy review the facility failed to administer all medications to Resident #100 the evening of admission. This affected one (Resident #100) out of three residents reviewed for medication administration upon admission. Facility census was 98. Findings include: Review of the medical record revealed Resident #100 was admitted on [DATE] and discharged on [DATE] with diagnoses that included acute osteomyelitis right ankle and foot, end stage renal disease, type 2 diabetes, ascites, and hemiplegia and hemiparesis. Review of the medication administration record (MAR) revealed Resident #100 did not receive Gabapentin (for pain) 200 milligram (mg), Nifedipine (treat high blood pressure) 90 mg, and Senna (laxative) 8.6 mg the evening of 08/10/24. Gabapentin and Nifedipine was available to be pulled from the facility emergency drug kit, and Senna was an over-the-counter medication that was available. The Medicare 5-day Minimum Data Set, dated dated dated [DATE] revealed Resident #100 was cognitively intact. Interview on 09/12/24 at 5:30 P.M. Director of Nursing (DON) verified Resident #100 did not receive the evening dose of Gabapentin, Nifedipine, and Senna on 08/10/24 and the medications were available to be pulled from the EDK or from the over-the-counter stock. Review of the medication administration policy dated 10/17/23 indicated that resident medications are to be administered in an accurate, safe, timely, and sanitary manner. New medications should begin on the same day unless the next dose is scheduled for the following day.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on interview and record review the facility failed to ensure residents were free from significant medications errors. This affected one (Resident #100) out of three residents reviewed for insulin administration. The facility census was 96. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE] and discharge on 08/14/24 with diagnoses of acute osteomyelitis, altered mental status, end-stage renal disease, type two diabetes mellitus with hyperglycemia requiring long-term use of insulin, ascites, hepatomegaly with splenomegaly, and chronic kidney disease. Review of the 5-day Minimum Data Set (MDS) 3.0 assessment completed on 08/28/24 indicated that Resident #100 was cognitively intact, required assistance with activities of daily living, and had diabetes mellitus. Review of progress notes dated 08/10/24 at 5:39 P.M. revealed Resident #100 was admitted to the facility via emergency medical services. The director of nursing and assistant director of nursing were notified of the new admission. Review of a comprehensive nursing evaluation completed on 08/10/24 confirmed Resident #100 was a diabetic. Blood sugar results from 08/11/24 showed Resident #100 had a blood sugar level of 145.0 milligrams/deciliter (mg/dl) at 7:30 A.M., which increased to 270 mg/dl by 11:30 A.M. Review of admission orders start date of 08/10/24 at 5:30 P.M. for Humalog KwikPen subcutaneous solution (100 units/ml). Review of hospital after-visit summary from the stay between 08/01/24 and 08/10/24 indicated a discharge order for Lispro (100 units/ml solution, 1 unit = 10 grams carbs) for every meal and at bedtime and an active hospital diagnosis of uncontrolled type 2 diabetes mellitus with hyperglycemia. Review of the medication administration record (MAR) from 08/10/24 to 08/12/24 revealed Resident #100 did not receive his Humalog KwikPen subcutaneous solution at 8:00 P.M. for his bedtime dose. Interview on 09/30/24 at 11:19 A.M. with Licensed Practical Nurse (LPN) #268 confirmed Resident #100 was admitted on her shift and did not receive the 5:30 P.M. or 8:00 P.M. insulin dose. LPN #268 noted the physician was notified regarding the orders and requests to approve them and confirmed Humalog KwikPen subcutaneous solution was available in the Pyxis medication dispensing system. LPN #268 confirmed that Resident #100 should have received his 8:00 P.M. dose from the night shift nurse. Interview on 09/30/24 at 2:33 P.M. the DON and Administrator confirmed Resident #100 missed his 5:30 P. M. and 8:00 P.M. administration of the Humalog KwikPen, stating that this medication was available in the Pyxis for immediate use. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/30/24 at 3:17 P.M. with unit manager (#149) confirmed Humalog KwikPen was accessible in the Pyxis, and the resident should have received the dose at 8:00 P.M. Review of the medication administration policy dated 10/17/23 indicated that resident medications are to be administered in an accurate, safe, timely, and sanitary manner. New medications should begin on the same day unless the next dose is scheduled for the following day. Review of diabetic management policies dated 09/22/23 emphasized that anti-diabetic agents are administered per physician order.