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	10/22/2024

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 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 closed medical record review, review of the facility investigation, resident and staff interviews, and facility policy review, the facility failed to conduct a thorough investigation of an allegation of sexual abuse reported by one resident (Resident #105). This affected one resident (#105) of three residents reviewed for abuse. The facility census was 105. Findings Include: Review of the closed medical record for Resident #105 revealed the resident was admitted on [DATE], a readmitted on 06/20/24, and a discharge date on 10/11/24. Medical diagnoses included end stage renal disease, bipolar disorder, schizophrenia, dependence on renal dialysis, chronic obstructive pulmonary disease (COPD), and cognitive communication deficit. Review of Resident #105's census revealed she was admitted to a semi-private room. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #105 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating the resident was cognitively intact. Resident #105 used a wheelchair and was dependent on staff assistance to complete toileting, bathing, lower body dressing, bed mobility, and transfers. Review of the Self Reported Incident dated 09/16/24 revealed Resident #105 alleged State tested Nursing Assistant (STNA) #200 inappropriately touched her while providing care to the resident. STNA #200 was suspended pending an investigation. Resident #105 was assessed without any indications of trauma or injury found. Resident #105 denied pain or discomfort. Resident #105 and STNA #200 were interviewed. STNA #200 reported Resident #105 had a large watery bowel movement which required peri-care to be completed to clean Resident #105. STNA #200 reported using soap, water, and a washcloth to complete the care and denied inappropriately touching Resident #105 at any time during care. Additional aides, the charge nurse, and Nurse Supervisor were interviewed without any negative findings noted. Additional residents were questioned with no negative findings noted. The facility staff were re-educated on the facility's abuse policy. The allegation was reported to the local police department and completed a report which reflected no crime had been committed. Resident #105 would receive care from female caregivers only following the incident. There was no evidence Resident #105's roommate (Resident #47) was interviewed related to the allegation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview via telephone on 10/17/24 at 12:08 P.M. with Resident #105 revealed the resident was currently hospitalized for an unrelated medical condition. Resident #105 confirmed an allegation of sexual abuse was made when STNA #200 had started to clean her up and inserted three fingers inside her three times. Resident #105 reported she asked STNA #200 to stop but the aide did not stop. Resident #105 stated she attempted to report the incident on 09/13/24 (the same day the incident allegedly occurred) to a person in authority but there was not any staff available to take her report. Resident #105 reported the incident/allegation to Activities Aide (AA) #204 on 09/15/24. Resident #105 stated she also spoke to her roommate, Resident #47, about the incident. Resident #47 advised her to report the incident to the facility staff. Resident #105 denied the facility staff asked the resident if she wanted to go to the hospital to be evaluated. The staff did ask if Resident #105 wanted to file a police report. Resident #105 filed a police report on 09/15/24. Interview on 10/17/24 at 12:49 P.M. with STNA #200 via telephone revealed he provided peri-care to Resident #105 on 09/13/24. STNA #200 denied he inappropriately touched Resident #105 in any way while providing her personal care. STNA #200 denied Resident #105 asked him to stop providing care at any time and said thank you to the aide when he finished the care. Interview on 10/17/24 at 1:21 P.M. with Activities Aide (AA) #204 confirmed Resident #105 had requested to speak with Activities Director (AD) #202 for about two days but AD #202 was too busy to discuss the resident's concerns so AA #204 discussed Resident #105's concerns instead. AA #204 stated Resident #105 reported she had liquid diarrhea and an aide stuck his fingers inside of her. At that time, AA #204 escorted Resident #105 to the ADON's office. AA #204 stated he was not interviewed by any of the facility staff regarding the alleged incident between Resident #105 and STNA #200. Interview on 10/17/24 at 1:34 P.M. with AD #202 confirmed Resident #105 would frequently come to the activities room and talk with him. AD #202 stated Resident #105 requested to speak with him about something on 09/13/24 but he forgot to follow up with the resident before he left the facility for the day. AD #202 contacted AA #204 and requested he follow up with Resident #105. AA #204 had also left the facility for the day and was not able to follow up with Resident #105 until 09/15/24. AD #202 confirmed he was not interviewed by any facility staff regarding the alleged incident between Resident #105 and STNA #200. Interview on 10/17/14 at 2:30 P.M. with the Administrator and Assistant Director of Nursing (ADON) revealed Resident #47 was interviewed by the police, however, confirmed there was not any evidence Resident #47 was interviewed by the facility staff during their investigation of the alleged incident between Resident #105 and STNA #200. The ADON confirmed the residents who were highlighted in yellow were interviewable residents and should have been interviewed. The ADON and the Administrator confirmed Resident #47 was highlighted, however, her name had been crossed out. Neither the Administrator nor the ADON could explain why Resident #47's name had been crossed out and could not provide any additional evidence that Resident #47 had been interviewed about the alleged incident. The ADON and the Administrator confirmed neither AA #204 or AD #202 were interviewed about the alleged incident as they stated they were not aware either of these staff had any contact with Resident #105. The Administrator and ADON confirmed the facility's policy was to interview any staff who had contact with the resident during the period when the incident occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/17/24 at 3:02 P.M. with Resident #47 confirmed Resident #105 was her roommate at the time of the alleged incident on 09/13/24. Resident #47 confirmed Resident #105 reported the incident to her on the day it occurred. Resident #47 stated, she told me exactly what happened and I knew it happened because she (Resident #105) is not a liar. However, Resident #47 reported she did not hear Resident #105 asked STNA #200 to stop providing care or yell out at any time. Resident #47 denied any facility staff had interviewed her about the alleged incident or asked if she had witnessed anything inappropriate between STNA #200 and Resident #105. Resident #47 stated she was interviewed by a sexual assault detective on 10/16/24. The resident stated she had not been interviewed by anyone about the incident prior to 10/16/24. Review of the facility policy, Abuse Prohibition Policy, revised 09/09/22, revealed the policy stated, an abuse investigation may consist of: review of the completed incident report, interview with person(s) reporting the incident, interviews with any witnesses to the incident, an interview with the resident if possible, interviews with staff members having contact with the resident during the period/shift of the alleged incident, interviews with the resident's roommate, family members, and visitors, and review of all circumstances surrounding the incident. This deficiency represents non-compliance investigated under Complaint Number OH00158654 and is an example of continued non-compliance from the survey dated 09/30/24.