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	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamilton 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and facility policy review, the facility failed to ensure call lights were accessible for use. This affected two residents (#32 and #79) of 14 sampled residents. The facility census was 107.Findings Include:1. Review of the medical record for Resident #79 revealed an initial admission date of 12/17/20 with the diagnoses including but not limited to multiple sclerosis, diabetes mellitus, vitamin D deficiency, anxiety disorder, encounter for palliative care, opioid use, pain, cerebellar ataxia, history of falling, severe protein malnutrition, hypertension, chronic pain syndrome and adult failure to thrive. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. On 08/08/25 at 10:18 A.M., observation of Resident #32 revealed the resident's call light was laying on the floor at the bottom of the bed out of the resident's reach. Interview with Certified Nursing Assistant (CNA) #203 verified the resident's call light was out of reach. 2. Review of the medical record for Resident #32 revealed an initial admission date of 06/20/25 with the diagnoses including but not limited to metabolic encephalopathy, generalized muscle weakness, cognitive communication deficit, tremor, white matter disease, moderate protein calorie malnutrition, hypertensive heart disease without failure, hyperlipidemia, constipation and need for assistance with personal care. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive impairment. On 08/12/25 at 9:30 A.M., observation of Resident #32 revealed the resident's call light was clipped to the enabler bar hanging down out of the resident's reach. On 08/12/25 at 9:35 A.M., interview with Registered Nurse (RN) #172 verified the resident's call light was not within reach. Review of the facility policy titled, Call Lights, dated 03/12/25 revealed call light will be placed within the resident's reach and answered in a timely manner.This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to notify the physician and the resident's family of a new skin impairment. This affected one resident (#79) of three residents reviewed for pressure ulcers. The facility census was 107. Findings Include:Review of the medical record for Resident #79 revealed an initial admission date of 12/17/20 with the diagnoses including but not limited to multiple sclerosis, diabetes mellitus, vitamin D deficiency, anxiety disorder, encounter for palliative care, opioid use, pain, cerebellar ataxia, history of falling, severe protein malnutrition, hypertension, chronic pain syndrome and adult failure to thrive. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was dependent on staff for all activities of daily living (ADL). Review of the weekly skin and wound evaluation dated 08/07/25 revealed the resident was found to have an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the right lateral elbow measuring 3.2 centimeters (cm) by 4. 9 cm by less than 0.1 cm and described as 60% granulation tissue and 40% eschar (dead or devitalized tissue). The wound had a moderate amount of serosanguineous exudate. The facility continued the same treatment. The facility determined the wound had deteriorated. The note indicated the resident had a skin tear medial to the wound bed and it conjoined with the pressure ulcer which was the reasoning for the larger measurements in surface area. Review of the medical record revealed no documentation on when the skin tear was found, how the skin tear occurred or documented evidence the resident's family or physician was notified of the skin tear. On 08/11/25 at 12:10 P.M., interview with Registered Nurse (RN) #147 verified the facility had no documentation of when, how the skin tear occurred or the physician and family were notified of the skin tear to her right elbow. Review of the facility policy titled, Notification of Change, last revised 02/14/24 revealed the facility must inform the resident, consult with the resident's practitioner and notify consistent with his or her authority, the resident representative when there is a change in status. A change in status would include the following, a need to alter treatment significantly, that is need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure resident rooms were maintained in a clean and sanitary manner. This affected four residents (#10, #11, #12, #67) of 107 residents. The facility census was 107.Findings include:1.Review of Resident #10's medical record revealed an admission date of 12/14/23 with diagnoses including spinal stenosis, anxiety disorder, cognitive communication deficit, depression, and type two diabetes mellitus.Review of Resident #10's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition.Observation on 08/11/25 at 2:50 P.M. of Resident #10's room revealed a build up debris under her bed including bits of plastic. 2.Review of Resident #11's medical record revealed the resident admitted on [DATE] with diagnoses including unspecified mood disorder, type two diabetes mellitus, cerebral infarction, aphasia, and hemiplegia and hemiparesis affecting left non-dominant side.Review of Resident #11's five-day MDS 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. Observation on 08/11/25 at 2:50 P.M. of Resident #11's room revealed brown splatters next to Resident #11's bed and her bedside table was covered in numerous white stains. 3.Review of Resident #12's medical record revealed an admission date of 06/04/22 with diagnoses including Alzheimer's disease, muscle weakness, dysphagia, legal blindness, and cerebrovascular disease.Review of Resident #12's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition.Observation on 08/11/25 beginning at 10:42 A.M., 2:50 P.M., and 4:20 P.M. of Resident #12's room revealed her comforter had multiple yellow stains and had food caked on it. The wall next to her bed had unidentifiable black splatters covering it.4.Review of Resident #67's medical record revealed an admission date of 08/25/21 with diagnoses including dysphagia, cerebral infarction, unspecified dementia, major depressive disorder, and hemiplegia and hemiparesis affecting left non-dominant side.Review of Resident #67's five-day MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition.Observation on 08/11/25 at 4:20 P.M. of Resident #67's room revealed the wall next to her bed had brown splatters and under her bed had a buildup of dust and various items including straws and bits of plastic. Additionally, her bedside table was covered in unidentifiable stains. Interview on 08/11/25 at 4:20 P.M. with the Administrator verified the above observations in resident rooms.Review of the policy ‘Housekeeping Services' dated 07/11/25 revealed thorough scrubbing was to be used for all environmental surfaces cleaned in resident areas. Areas to be cleaned in resident rooms included all horizontal flat surfaces, over bed tables and walls should be spot cleaned if visibly soiled. This deficiency represents noncompliance investigated under Complaint Number 1399441.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, review of facility investigation and self-reported incidents (SRI), and facility policy review, the facility failed to ensure Resident #112 was free from verbal abuse. This affected one resident (#112) of one resident reviewed for verbal abuse. The facility also failed to prevent an injury of unknown origin for Resident #79. This affected one resident (#79) of three residents reviewed for injuries. The facility census was 107.Findings include:1.Review of Resident #112’s medical record revealed an admission date of 06/12/25 and a discharge date of 07/18/25, his diagnoses included type two diabetes mellitus, unspecified corneal ulcer, muscle weakness, and gastro-esophageal reflux disease. Review of the facility self-reported incident dated 06/17/25 revealed the facility reported an incident of emotional or verbal abuse due to a resident and staff member arguing over the meal served for breakfast. The resident was Resident #112 and he had no adverse effects from the incident. The alleged perpetrator was Former [NAME] #233. The incident occurred on 06/17/25 at 9:45 A.M. the Administrator was contacted by the Director of Nursing (DON). A Certified Nursing Assistant (CNA) had requested that Former [NAME] #233 speak to Resident #112 about his breakfast as he was requesting more food. While they were speaking the conversation became heated. A nurse, who was also in the room, requested the cook leave. The nurse was able to convince the cook to leave and return to the kitchen, however, Resident #112 entered the hallway and called the cook several derogatory names. The cook stopped but was convinced to return to the kitchen. The DON was notified of the concern and came to the hallway to assess the situation. The DON went to the cook and asked him to clock out pending an investigation, he did this and left the facility. The facility reported the incident as unsubstantiated. The staff member was terminated due to poor customer service. Review of the witness statement dated 06/17/25, by Assistant Director of Nursing (ADON) #128 revealed she was in morning meeting when Licensed Practical Nurse (LPN) #221 called and stated there was an employee from the kitchen arguing with Resident #112. The ADON informed the Director of Nursing (DON), when they arrived Resident #112 was speaking to another staff member. The resident stated he had been having issues with receiving double portions since he arrived at the facility even though it was listed on his tray ticket. He asked the CNA if she could ask the kitchen to send him another tray. Former [NAME] #233 came in to his room yelling and hitting his hands together. Resident #112 said he began to argue back and forth with the cook and he was not going to allow the cook to speak to him that way. He stated Former [NAME] #233 began to act as if he was trying to get near him to fight, but other staff were able to get him to leave the room. Resident #112 followed him down the hallway calling him a ‘crack head’. Resident #112 stated someone from housekeeping had to hold Former [NAME] #233 back. Review of the witness statement dated 06/17/25 by LPN #221 revealed she overheard a resident and kitchen staff arguing over a breakfast tray. Words were exchanged and she heard Resident #112 say ‘Don’t send crackheads to my room.’ The cook was asked to return to the kitchen. As LPN #221 was walking to the nurse’s station with Resident #112 she noted the kitchen staff member was at the desk. A housekeeper grabbed Former [NAME] #233, holding him back. Resident #112 was taken to his room where the ADON and DON arrived to speak to them. LPN #221 reported she felt the staff member should have returned to the kitchen until management was present. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the witness statement dated 06/17/25 by Registered Nurse (RN) #131 revealed she had been administering medication when she heard Resident #112 and Former [NAME] #233 arguing. RN #131 went to the resident room and asked Former [NAME] #233 to leave; however, he did not leave and the argument began escalating. The nurse had to push Resident #233 out of the room and to the kitchen. The resident began following RN #131 and Former [NAME] #233 down the hallway. Former [NAME] #233 went back outside the kitchen and the argument began again. The other nurse called the DON and other manager, and the resident was helped back to his room. Review of the witness statement by Laundry Aide #220 revealed they had been filling closets and saw Former [NAME] #233 walking towards the kitchen. Resident #112 was behind him calling him a ‘crack head’ Former [NAME] #233 turned around and was staring at the resident. Laundry Aide #220 took Former cook #233 by the arm and took him to the kitchen. Review of the Disciplinary Action Record dated 06/23/25 revealed Former [NAME] #233 was hired on 11/20/22. He was receiving a disciplinary action related to an incident on 06/17/25 where he had a heated conversation with a resident, he was in violation of work rule 41. Review of the consolidated employee handbook revised 06/04/24 revealed rule number 41 was that staff members may not be loud, discourteous, use profane or abusive language to any other staff member, visitor, person, or resident in the facility. Interview on 08/12/25 at 11:00 A.M. with LPN #221 revealed on 06/17/25 she had been in the middle of medication pass when she heard yelling and screaming. She went to the resident’s room, and he was clearly upset and the kitchen staff member was in the doorway. They were arguing about breakfast and Former [NAME] #233 was raising his voice telling him they did not have extra food. LPN #221 indicated she stepped and told Former [NAME] #221 he needed to go back to his area. He started walking away; however, more words were exchanged, and she had to step in between them. As Former [NAME] #233 was walking back to the nurse’s station, the resident followed cursing at him and the cook was yelling back. LPN #221 called the ADON. The kitchen staff member stayed at the nurse’s station and did not back down, he continued yelling at the resident until a housekeeper took his arm and walked him back to the kitchen. LPN #221 reported the cook had been cussing at the resident as well, but she did not recall anything specific that was said. Interview on 08/12/25 at 11:42 A.M. with the Administrator verified the 06/23/25 disciplinary action was Former [NAME] #233 being terminated. They did not have a formal statement from him. Interview on 08/12/25 at 11:11 A.M. with Resident #112 revealed prior to the 06/17/25 he had problems getting double portions with meals as ordered. He reported it was on his tray ticket; however, the kitchen was not providing the extra food. On 06/17/25 he asked to speak to the cook to get the issue fixed. Former [NAME] #233 came in and ask what he wanted. Resident #112 told the cook this had been a problem he talked about to three different people and he wanted to speak to someone who was going to ensure it was fixed. Resident #112 reported Former [NAME] #233 immediately began yelling, stating he made the plate and gave him the right food. He was slamming his right hand into his left palm as he yelled. Resident #112 stated he went to stand, and the cook told him that if he swung at him he would punch him. Resident #112 stated this was when he began upset, because this clearly had not been the right person to speak to. He stated Former [NAME] #233’s anger went from zero to 10 quickly and felt it was a sign of drug use. He called him a crack head. The facility asked if he wanted to press charges and he did not. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy ‘Abuse Prohibition policy’ dated 10/14/22 revealed each resident was to be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. Verbal use was defined as the use of verbal or nonverbal conduct which caused or had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. 2. Review of the medical record for Resident #79 revealed an initial admission date of 12/17/20 with the diagnoses including but not limited to multiple sclerosis, diabetes mellitus, vitamin D deficiency, anxiety disorder, encounter for palliative care, opioid use, pain, cerebellar ataxia, history of falling, severe protein malnutrition, hypertension, chronic pain syndrome and adult failure to thrive. Review of the resident’s comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was dependent on staff for all activities of daily living (ADL). Review of the weekly skin and wound evaluation dated 08/07/25 revealed the resident was found to have an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the right lateral elbow measuring 3.2 centimeters (cm) by 4.9 cm by less than 0.1 cm and described as 60% granulation tissue and 40% eschar (dead or devitalized tissue). The wound had a moderate amount of serosanguineous exudate. The facility continued the same treatment. The facility determined the wound had deteriorated. The note indicated the resident had a skin tear medial to the wound bed and it conjoined with the pressure ulcer which was the reasoning for the larger measurements in surface area. Review of the medical record revealed no documentation on when the skin tear was found or how the skin tear occurred. On 08/11/25 at 12:10 P.M., interview with Registered Nurse (RN) #147 verified the facility had no documentation of when and how the skin tear occurred. On 08/12/15 at 12:45 P.M., an interview with the Director of Nursing (DON) revealed she spoke with Registered Nurse (RN) #128 and the wound was from the resident’s Broda chair because her hospice company documented her up in the chair on 08/02/25 and she called the resident’s company and requested the resident hospice notes. Review of the facility policy titled, “Abuse Prohibition Policy,” last revised 09/09/22 revealed each resident shall be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. This deficiency represents noncompliance investigated under Complaint Number 1399441.

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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** Based on medical record review, interview and facility policy review, the facility failed to ensure an injury of unknown origin was reported to the required state agency. This affected one resident (#79) of three residents reviewed for pressure ulcers. The facility census was 107. Findings Include:Review of the medical record for Resident #79 revealed an initial admission date of 12/17/20 with the diagnoses including but not limited to multiple sclerosis, diabetes mellitus, vitamin D deficiency, anxiety disorder, encounter for palliative care, opioid use, pain, cerebellar ataxia, history of falling, severe protein malnutrition, hypertension, chronic pain syndrome and adult failure to thrive. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was dependent on staff for all activities of daily living (ADL). Review of the weekly skin and wound evaluation dated 08/07/25 revealed the resident was found to have an unstageable(Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the right lateral elbow measuring 3.2 centimeters (cm) by 4. 9 cm by less than 0.1 cm and described as 60% granulation tissue and 40% eschar (dead or devitalized tissue). The wound had a moderate amount of serosanguineous exudate. The facility continued the same treatment. The facility determined the wound had deteriorated. The note indicated the resident had a skin tear medial to the wound bed and it conjoined with the pressure ulcer which was the reasoning for the larger measurements in surface area. Review of the medical record revealed no documentation on when the skin tear was found or how the skin tear occurred. On 08/11/25 at 12:10 P.M., interview with Registered Nurse (RN) #147 verified the facility had no documentation of when and how the skin tear occurred. On 08/12/15 at 12:45 P.M., an interview with the Director of Nursing (DON) verified the medical record contained no documented evidence of how or when the skin tear occurred. The DON verified the facility had not reported the injury of unknown origin to the state agency. Review of the facility policy titled, Abuse Prohibition Policy, last revised 09/09/22 revealed each resident shall be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. The staff will report an allegation or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property and injuries of unknown origin source to the Administrator and DON immediately. The Administrator or designee will notify the resident's representative and also any state and federal agencies of allegation per state guidelines.This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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** Based on medical record review, interview and facility policy review, the facility failed to ensure an injury of unknown origin was investigated. This affected one resident (#79) of three residents reviewed for pressure ulcers. The facility census was 107. Findings Include:Review of the medical record for Resident #79 revealed an initial admission date of 12/17/20 with the diagnoses including but not limited to multiple sclerosis, diabetes mellitus, vitamin D deficiency, anxiety disorder, encounter for palliative care, opioid use, pain, cerebellar ataxia, history of falling, severe protein malnutrition, hypertension, chronic pain syndrome and adult failure to thrive. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was dependent on staff for all activities of daily living (ADL). Review of the weekly skin and wound evaluation dated 08/07/25 revealed the resident was found to have an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the right lateral elbow measuring 3.2 centimeters (cm) by 4.9 cm by less than 0. 1 cm and described as 60% granulation tissue and 40% eschar (dead or devitalized tissue). The wound had a moderate amount of serosanguineous exudate. The facility continued the same treatment. The facility determined the wound had deteriorated. The note indicated the resident had a skin tear medial to the wound bed and it conjoined with the pressure ulcer which was the reasoning for the larger measurements in surface area. Review of the medical record revealed no documentation on when the skin tear was found or how the skin tear occurred. On 08/11/25 at 12:10 P.M., interview with Registered Nurse (RN) #147 verified the facility had no documentation of when and how the skin tear occurred. On 08/12/15 at 12:45 P.M., an interview with the Director of Nursing (DON) revealed she spoke with Registered Nurse (RN) #128 and the wound was from the resident's Broda chair because her hospice company documented her up in the chair on 08/02/25 and she called the resident's company and requested the resident hospice notes. The DON verified the resident's medical record contained no documented evidence the resident had a skin tear to her right elbow, when the skin tear occurred or how the skin tear occurred. Review of the facility policy titled, Abuse Prohibition Policy, last revised 09/09/22 revealed each resident shall be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. The DON or designee will complete and assessment of the resident and document the findings. An incident report will be completed. The licensed nurse will notify the physician if required and notify the family member/responsible party/emergency contact/legal guardian. A preliminary, no-site investigation will be initiated with 24 hours of any report.This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to appropriately document a transfer and discharge and provide a transfer notice for Resident #108 and #109. This affected two residents (#108 and #109) of five discharge records reviewed. The facility census was 107.Findings include: 1.Review of the medical record for Resident #109 revealed an admission date of 01/15/25 and a discharge date of 04/13/25 with diagnoses including pneumonia, cognitive communication deficit, generalized anxiety disorder, and chronic respiratory failure. Review of Resident #109’s progress note dated 04/13/25 revealed the resident had a fall and hit her head. Emergency medical services were called, and the resident was sent to the hospital. Review of Resident #109’s medical record revealed no transfer or discharge summary was completed and no transfer notice was provided. Interview on 08/07/25 at 1:13 P.M. with the Director of Nursing (DON) verified there was insufficient documentation related to Resident #109’s discharge. 2. Review of the closed medical record for Resident #108 revealed an initial admission date of 04/26/25 with the latest readmission of 06/13/25 with the diagnoses including but not limited to other mechanical complication of surgically created arteriovenous (AV) fistula, acquired absence of other left toes, encounter for orthopedic aftercare following surgical amputation, generalized muscle weakness, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease or end stage renal disease, end stage renal disease (ESRD), diabetes mellitus, pressure induced deep tissue injury (DTI) to left heel, DTI to left ankle, atrial fibrillation, anemia, opioid use, depression, urinary tract infection, chronic obstructive pulmonary disease, open-angle glaucoma right eye, asthma, arteriovenous fistula, long term use of insulin, pulmonary hypertension, long term use of anticoagulants, dependence on renal dialysis, chronic congestive heart failure, personal history of malignant neoplasm of prostate, peripheral vascular disease, alcohol abuse, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, cardiomyopathy, hyperlipidemia, constipation and atherosclerotic heart disease. Review of the change in condition progress note dated 05/13/25 at 7:02 P.M. revealed the resident was having difficulty breathing and oxygen saturation rate was 66% on room air. Two liters of oxygen was administered and his oxygen saturation rate increased to 95%. The physician on call was notified but the resident’ daughter who was at the facility visiting insisted the resident be sent to the local ER for an evaluation. The on call physician was made aware and the resident was sent to the local acute care hospital for an evaluation. Review of the Telehealth progress note dated 05/13/25 revealed the resident’s oxygen saturation rate dripped to 66% on room air. The resident was placed on four liters of oxygen and his oxygen saturation rated increased to 92%. The resident was confused and short of breath. The resident’s family was at bedside and insisted on the resident being sent to the local emergency room (ER) for an evaluation. Review of the resident's Discharge summary dated [DATE] revealed the summary was blank. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamilton 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/15 at 12:45 P.M., an interview with the Director of Nursing (DON) verified the discharge summary was blank. Review of the facility policy titled, Transfer and Discharge, last revised 04/22/25 revealed the transfer and discharge process must provide sufficient preparation and orientation of residents to ensure a safe and orderly transfer or discharge from the facility. When a resident is transferred on an emergency basis to an acute care facility a transfer from is completed, a list of medications and a copy of the care plan goals is sent to the receiving hospital. Nursing documents the hospital transfer in the medical record. Further review revealed a notice of transfer or discharge must be made by the facility in writing 30 days before the resident was transferred or discharged . The exception to this was when the resident’s welfare was at risk such as an emergency transfer, however, the notice must be made as soon as practicable. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were completed accurately for Resident #108 and Resident #109. This affected two residents (#108 and #109) of 19 medical records reviewed. The facility census was 107.Findings include:1.Review of the medical record for Resident #109 revealed an admission date of 01/15/25 and a discharge date of 04/13/25 with diagnoses including pneumonia, cognitive communication deficit,2109 generalized anxiety disorder, and chronic respiratory failure. Review of Resident #109’s MDS assessments revealed the last one completed was on 04/13/25 and indicated ‘discharge return anticipated’. Review of Resident #109’s medical record revealed she did not return to the facility following her transfer to the hospital on [DATE]. Interview on 08/13/25 at 1:05 P.M. with MDS Nurse #215 verified Resident #109’s MDS assessment was not correct, she had not returned to the facility. 2 . Review of the closed medical record for Resident #108 revealed an initial admission date of 04/26/25 with the latest readmission of 06/13/25 with the diagnoses including but not limited to other mechanical complication of surgically created arteriovenous (AV) fistula, acquired absence of other left toes, encounter for orthopedic aftercare following surgical amputation, generalized muscle weakness, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease or end stage renal disease, end stage renal disease (ESRD), diabetes mellitus, pressure induced deep tissue injury (DTI) to left heel, DTI to left ankle, atrial fibrillation, anemia, opioid use, depression, urinary tract infection (UTI), chronic obstructive pulmonary disease (COPD), pulmonary hypertension, long term use of anticoagulants, dependence on renal dialysis, chronic congestive heart failure, peripheral vascular disease, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, cardiomyopathy, hyperlipidemia and atherosclerotic heart disease. Review of the resident’s readmission nursing comprehensive evaluation dated 05/29/25 revealed the resident was admitted to the facility with open sores from scratching to the right antecubital area and right elbow. The evaluation did not address the multiple vascular wounds to his left foot. Review of the resident’s five-day MDS assessment dated [DATE] revealed the resident had no cognitive impairment. The assessment indicated the resident was at risk for skin breakdown, had no skin issues. Review of the resident’s skin and wound evaluation dated 06/13/25 revealed the resident was readmitted to the facility with an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the resident’s right heel. The wound was described as having slough and/or eschar (dead or devitalized tissue). The assessment had no measurements for the wound. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident’s five-day MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent for toileting, bathing, transfers, required substantial/maximal assistance with dressing and required partial/moderate assistance for bed mobility. The assessment indicated the resident was at risk for skin breakdown and had two unstageable pressure ulcers on admission and one deep tissue injury present on admission. The MDS did not address the vascular wounds to the resident’s right first and second toes. On 08/12/25 at 11:13 A.M., an interview with Minimum Data Set (MDS) Coordinator #215 verified the resident's MDS assessments did not reflect the vascular wound on his left and right feet. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and review of facility policy, the facility failed to develop a detailed and comprehensive care plan for Resident #19, #26, #27, #34, #79, and #108. This affected six residents (#19, #26, #27, #34, #79, and #108) of 19 resident records reviewed. The facility census was 107. Findings include: 1.Review of Resident #108’s medical record revealed an admission date of 04/26/25 and a discharge date of 06/24/25 with diagnoses including muscle weakness, end stage renal disease with dependence on dialysis, type two diabetes mellitus, fracture of sacrum, pressure induced deep tissue damage of left heel, pressure ulcer of left ankle, chronic obstructive pulmonary disease, alcohol abuse, and peripheral vascular disease. Review of Resident #108’s five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #108’s plan of care dated 04/26/25 revealed ‘preferred name’ was at risk for complications related to dialysis. Interventions included encouraging him to go for the scheduled appointments, observing for signs of fluid retention, observing for signs of infection to access site, observing for bruising or bleeding, and palpitating for the presence of thrill and listen for bruit as needed. The plan of care was not specific to the resident, did not include where he went to dialysis, how to contact them, or when he was to go to dialysis. Review of Resident #108’s plan of care dated 04/26/25 revealed ‘preferred name’ was at risk for pain; it did not indicate why the resident was at risk for pain. Interventions included nonpharmacological interventions to prevent and manage pain as needed, anticipating residents’ need for pain relief, notifying if interventions are unsuccessful, observing and reporting changes in routine, and observing for side effect of pain meds. The plan of care was not specific to the resident. Review of Resident #108’s plan of care dated 04/26/25 revealed ‘preferred name’ was at risk for fall related injury and falls, it did not indicate why the resident was at risk. Interventions included dycem to wheelchair, encouraging appropriate footwear, keeping a safe environment, moving closer to nurses’ station, and offering and encouraging toileting after breakfast. The plan of care was not specific to the resident. Review of Resident #108’s medical record revealed he had been in the facility for over 14 consecutive days from 4/26/25 to 05/13/25. Interview on 08/11/25 at 1:07 P.M. with MDS Nurse #215 verified Resident #108’s care plan was not specific to the resident. She reported this was due to him being in and out of the facility with hospitalizations. 2. Review of Resident #34’s medical record revealed an admission date of 04/18/25 with diagnoses including chronic heart failure, chronic obstructive pulmonary disease, muscle weakness, chronic kidney disease stage four, anxiety disorder, and chronic respiratory failure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #34’s quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #34’s plan of care dated 04/18/25 revealed ‘preferred name’ was incontinent of bowel and bladder; the plan of care did not indicate what this was related to. Interventions included only brief usage and checking every two hours and as needed for incontinence. Review of Resident #34’s plan of care dated 04/18/25 revealed ‘preferred name’ had a functional ability deficit and required assistance with self-care and mobility; the plan of care did not indicate what this was related to. There were no interventions related to this. Review of Resident #34’s plan of care dated 04/18/25 revealed ‘preferred name’ was at risk for fall related injury and falls, the plan of care did not indicate what this was related to. There were only two interventions providing two-person assistance with ambulation and mechanical lift for transfers. Interview on 08/11/25 at 1:07 P.M. with MDS Nurse #215 verified her care plan was not complete. She reported she thought the other MDS nurse had completed it, and she had not. 3. Review of Resident #26’s medical record revealed an admission date of 06/18/25 with diagnoses including chronic heart failure, acute respiratory failure, end stage renal disease, diabetes mellitus, and depression. Review of Resident #26’s MDS 3.0 assessment dated [DATE] revealed he had intact cognition. Review of Resident #26’s plan of care on 08/11/25 revealed it did not address any discomfort or pain the resident experienced or oxygen usage. Review of Resident #26’s physician order dated 07/23/25 revealed an order for hydrocodone-acetaminophen 325 milligrams (mg) one tablet by mouth every eight hours as needed for pain. Interview on 08/11/25 at 1:07 P.M. with MDS Nurse #215 verified Resident #26 did not have a pain plan of care and should have. 4. Review of Resident #27’s medical record revealed an admission date of 06/06/25 with diagnoses including metabolic encephalopathy, chronic respiratory failure, chronic heart failure, and moderate protein-calorie malnutrition. Review of Resident #27’s comprehensive MDS assessment dated [DATE] revealed he had intact cognition. Review of the plan of care dated 6/6/25 revealed ‘preferred name’ had a functional ability deficit and required assistance with self-care mobility, it did not indicate what this was related to. Interventions did not include the residents specific activity of daily living needs. Interview on 08/12/25 at 11:08 A.M. with MDS Nurse #215 verified the care plan was not complete. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record for Resident #19 revealed an initial admission date of 04/24/25 with the diagnoses including but no limited to congestive heart failure, atrial fibrillation, hypertension, rheumatoid arthritis, insomnia, hyperlipidemia, vascular dementia, osteoporosis, arthritis, constipation, sensorineural hearing loss and adult failure to thrive. Review of the resident’s admission nursing comprehensive evaluation dated 04/18/25 revealed the resident was continent of both bowel and bladder. Review of the resident’s comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent on staff for toileting and transferring to the toilet was not attempted. The assessment indicated the resident was frequently incontinent of both bowel and bladder. Review of the quarterly nursing comprehensive evaluation dated 07/18/25 revealed the resident was continent of both bowel and bladder. Review of the resident’s quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent on staff for toileting and transferring to the toilet. The assessment indicated the resident was always incontinent of both bowel and bladder. Review of the plan of care revealed the resident had no care plan addressing resident's bowel and bladder function. On 08/12/25 at 1:14 P.M., interview with the Minimum Data Set (MDS) Coordinator #215 verified the resident had no plan of care addressing her bowel and bladder incontinence. 6. Review of the medical record for Resident #79 revealed an initial admission date of 12/17/20 with the diagnoses including but not limited to multiple sclerosis, diabetes mellitus, vitamin D deficiency, anxiety disorder, encounter for palliative care, opioid use, pain, cerebellar ataxia, history of falling, severe protein malnutrition, hypertension, chronic pain syndrome and adult failure to thrive. Review of the plan of care dated 07/23/25 revealed the resident had actual impaired skin integrity related to pressure injury stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister) right gluteus and right lateral elbow. Interventions included observe for signs of discomfort with dressing changes and administer pain, refer to Dietician as needed, specialty bed as ordered and treatment as ordered. Review of the Wound Nurse Practitioner (WNP) progress note dated 07/24/25 at 8:00 A.M. revealed the resident was found to have an unstageable (Known but not stageable due to coverage of wound bed by slough and/or eschar pressure ulcer to the right gluteus measuring 2.3 cm by 1.9 cm by 0.1 cm and the wound was described as being 30% granulation and 70% slough. The wound had a moderate amount of serosanguineous drainage. The NP ordered the treatment cleanse with NS, apply Therahoney and calcium alginate and cover with bordered foam daily and as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the WNP progress note dated 07/31/25 at 8:00 A.M. revealed the resident was found to have an unstageable pressure ulcer to the right gluteus measuring 3.1 cm by 1.7 cm and the wound was described as being 30% granulation and 70% slough. The facility determined the wound had deteriorated. The progress note also indicated the resident was found to have an unstageable pressure ulcer to the right elbow measuring 1.8 cm by 1.2 cm was described as being 10% granulation and 90% slough. The wound had a moderate amount of serosanguineous exudate. Review of the WNP progress note dated 08/07/25 at 8:00 A.M. revealed the resident was found to have an unstageable pressure ulcer to the right gluteus measuring 2.6 cm by 2.0 cm and the wound was described as being 30% granulation and 70% slough. The wound had a moderate amount of serosanguineous drainage. The facility determined the wound had deteriorated. The progress note also indicated the resident was found to have an unstageable pressure ulcer to the right elbow measuring 2.3 cm by 1.9 cm by 0.1 cm and was described as being 30% granulation and 70% slough. The wound had a moderate amount of serosanguineous exudate. On 08/12/25 at 1:14 P.M., interview with the Minimum Data Set (MDS) Coordinator #215 verified the resident's plan of care reflected the resident having a stage II pressure ulcer instead of the actual unstageable pressure ulcer. Review of policy ‘Care planning’ dated 03/03/25 revealed the care plan must be specific, resident centered, individualized and unique to each resident. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, open and closed medical record review, interviews, hospital summary review and facility policy review, the facility failed to provide medical treatment with a change in condition, monitor, assess and ensure treatment was provided for skin conditions for one resident (#108). Additionally, the facility failed to report concerns with a transfer and monitor a bruise for Resident #109 who was on an anticoagulant (a medication that thins the blood) therapy. The facility also failed to monitor and assess a skin tear and bruise for Resident #106. Further review revealed the facility failed to ensure hospice information was available for review for Resident #79. This affected three residents (#106,#108 and #109) of three residents reviewed for skin conditions and one resident (#79) of one resident reviewed for hospice. The facility census was 107.Findings Include:1.Review of the closed medical record for Resident #108 revealed an initial admission date of 04/26/25 with the latest readmission of 06/13/25 with the diagnoses including but not limited to other mechanical complication of surgically created arteriovenous (AV) fistula, acquired absence of other left toes, encounter for orthopedic aftercare following surgical amputation, generalized muscle weakness, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease , end stage renal disease (ESRD), diabetes mellitus, pressure induced deep tissue injury (DTI)(persistent non-blanchable deep red, maroon or purple discoloration) to left heel, DTI to left ankle, atrial fibrillation, anemia, opioid use, depression, urinary tract infection (UTI), chronic obstructive pulmonary disease (COPD), pulmonary hypertension, long term use of anticoagulants, dependence on renal dialysis, chronic congestive heart failure, peripheral vascular disease, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, cardiomyopathy, hyperlipidemia and atherosclerotic heart disease. Review of the closed medical record and hospital records revealed Resident #108 had a history of peripheral vascular disease with procedures to improve blood flow dating back to 2021. The resident had procedures as recently as 11/24. Review of the resident’s admission nursing comprehensive evaluation dated 04/26/25 revealed the resident was admitted to the facility with generalized scabbing to the front of his right and left leg and both his arms from the resident scratching in various stages of healing. Review of the resident’s comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident required substantial/maximal assistance with toileting, bathing, dressing, bed mobility and transfers were not attempted. The assessment indicated the resident was at risk for skin breakdown and had no skin issues. The facility implemented a pressure reducing device to his bed. Review of the progress note dated 05/09/25 at 12:15 P.M., revealed the resident was observed on the floor in his room in front of the bathroom door. The resident was alert but confused and able to follow instructions to some extent. The resident had a skin tear to his right elbow and left upper ankle. Review of the progress noted dated 05/09/25 at 2:09 P.M. revealed skin assessment completed after recent fall and an area observed to left great toe, top of left toes and right elbow and a treatment was put in place. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the struck (due to inaccurate documentation) out skin and wound evaluation dated 05/09/25 revealed the resident was observed to have a deep tissue injury (DTI) to the left first digit measuring 1.9 centimeter (cm) by 1.8 cm and described as 100% epithelial tissue. The wound had no exudate and the peri-wound edges appeared flush with wound bed or as a slopping edge. The facility implemented the treatment to cleanse the area with normal saline (NS), apply a providone iodine soaked gauze, cover with ABD pad, wrap with Kerlix and secure with tape daily and as needed. Review of the medical record revealed no comprehensive assessment or treatment for the skin tears to the right elbow and the left ankle. Review of the resident’s discharge physician orders identified an order to cleanse the left great toe with normal saline (NS), pat dry, apply betadine soaked gauze, cover with ABD pad, wrap with kerlix and secure with tape daily and as needed for wound care. Review of the plan of care dated 05/09/25 revealed the resident had an actual impaired skin integrity related to pressure injury to left great toe. Interventions included conduct skin assessment weekly and measure area(s) and document characteristics, enhanced barrier precautions (EBP), observe for signs of discomfort with dressing changes and administer pain medication as ordered, refer to dietitian as needed and treatment as ordered. Review of the progress note dated 05/09/25 at 2:45 P.M. revealed the resident was observed on the floor at the nurses station. The resident was confused and disoriented. The resident could not remember what he was trying to do before he fell. Review of the medical record revealed no evidence the facility identified the change in the resident’s mental status. Review of the progress note dated 05/13/25 at 1:38 P.M. revealed the resident’ dialysis treatment was cut short for 30 minutes when he experienced seizure like symptoms according to dialysis nurse. The treatment was discontinued per nephrologist’s order. The resident’s blood pressure was 168/96. Review of the resident’s medical record revealed no documented evidence the facility identified the change in condition with the presentation of the seizure like symptoms with no history of seizures and the increased blood pressure. Further review revealed no assessment of the resident’s change of condition. Review of the change in condition progress note dated 05/13/25 at 7:02 P.M. revealed the resident was having difficulty breathing and oxygen saturation rate was 66% on room air. Two liters of oxygen was administered and his oxygen saturation rate increased to 95%. The physician on call was notified but the resident’ daughter who was at the facility visiting insisted the resident be sent to the local emergency room (ER) for an evaluation. The on call physician was made aware and the resident was sent to the local acute care hospital for an evaluation. Review of the Telehealth progress note dated 05/13/25 revealed the resident’s oxygen saturation rate dropped to 66% on room air. The resident was placed on four liters of oxygen and his oxygen saturation rated increased to 92%. The resident was confused and short of breath. The resident’s family was at bedside and insisted on the resident being sent to the local ER for an evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the hospital summary for encounter date of 05/13/25 through 05/29/25 revealed the resident was found with multiple vascular wounds to his left foot and was status post left lower extremity angiogram with left external iliac artery stent placement, superficial femoral artery (SFA)/popliteal laser atherectomy, left SFA balloon angioplasty, left popliteal artery sent, and left peroneal balloon angioplasty on 05/22/25. The amputation of the left toes was deferred at that time due to the vascular surgeon felt the toes were salvageable. Review of the resident’s readmission nursing comprehensive evaluation dated 05/29/25 revealed the resident was admitted to the facility with open sores from scratching to the right antecubital area and right elbow. The evaluation did not address the multiple vascular wounds to his left foot. Review of the progress note dated 05/30/25 at 5:41 P.M. revealed the resident’s second skin check was completed and redness was observed to the sacral area. Scabbed areas were observed to his bilateral arms and legs. Blackened areas were observed to his left first, second and third toes. A vascular consult was scheduled and orders to monitor were in place. Review of the medical record revealed no comprehensive assessment of the first, second and third toes of the left foot. Additionally, the facility did not begin monitoring the his toes until 06/02/25. Review of the Nurse Practitioner (NP) progress note dated 06/04/25 revealed she noted the resident was alert, oriented, answering questions appropriately, but appeared drowsy. The resident kept his eyes closed and reported he did not feel good. The resident’s vital signs were stable except his oxygen saturation was 86% on room air. The resident’s AV fistula to his right arm was swollen, warm to touch and painful. The fistula had a positive bruit and thrill. The resident was being transferred to the local ER for differential diagnoses of cellulitis versus deep vein thrombosis (DVT) at the fistula site. Review of the resident’s five-day MDS assessment dated [DATE] revealed the resident had no cognitive impairment. The assessment indicated the resident was at risk for skin breakdown, had no skin issues. The facility implemented pressure reducing device to bed and application of ointments/medications other than to feet. Review of the hospital summary from 06/04/25 through 06/13/25 revealed the resident was admitted to due to a malfunctioning AV fistula. On 06/05/25 the resident was found to have bilateral legs/feet ischemic ulcers versus deep tissue injury (DTI) that presented with dark, hard, intact skin to the left first, second and third toes, the right first and second toes. The resident presented with purple/red areas to heels and anterior toes. Further review on 06/09/25 revealed the resident had worsening dry gangrene of the left first to third toes and recommended vascular to reevaluate for a total metatarsal amputation (TMA) and the resident underwent a TMA on 06/12/25. There were no orders from the hospital for any antibiotics. Review of the resident’s skin and wound evaluation dated 06/13/25 revealed the resident was readmitted to the facility with an unstageable pressure ulcer to the resident’s right heel. The wound was described as having slough and/or eschar. The assessment had no measurements for the wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident’s medical record revealed no evidence a physician ordered treatment was put in place following the readmission to the facility on [DATE] until 06/16/25. Review of the resident’s discontinued physician ordered identified orders dated 06/16/25 cleanse left lateral ankle with normal saline (NS), pat dry, apply medihoney and calcium alginate, cover with ABD pad and wrap with Kerlix daily and as needed for wound care, cleanse left toe amputation surgical site with NS, pat dry, cover with ABD pad, wrap with kerlix and secure with ace wrap daily and as needed, cleanse wounds to right first and second toes with NS, pat dry, apply betadine and leave open to air daily for wound care, cleanse wound to right heel with NS, pat dry, apply medihoney and calcium alginate, cover with bordered gauze daily and as needed and cleanse left heel with NS, pat dry, apply betadine soaked gauze, cover with ABD pad, wrap with kerlix daily and as needed. Review of the NP progress note dated 06/16/25 revealed the NP progress notes had not addressed the TMA surgical site or the wounds to the resident’s feet and ankle. Review of the progress note dated 06/16/25 at 9:18 P.M. revealed the second skin assessment completed for admission on [DATE] revealed areas to left heel, left lateral ankle, right heel, right first toe and right second toes were observed. The surgical incision was closed with 25 staples related to left amputation of toes is approximated with some swelling and bruising. Review of the medical record revealed no comprehensive assessment of the wounds to his right first and second toes. Review of the medical record revealed no evidence the resident was evaluated by the facility Wound Nurse Practitioner (WNP) while at the facility on 06/19/25. Review of the resident’s five-day MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent for toileting, bathing, transfers, required substantial/maximal assistance with dressing and required partial/moderate assistance for bed mobility. The assessment indicated the resident was at risk for skin breakdown and had two unstageable pressure ulcers on admission and one deep tissue injury present on admission. The MDS did not address the vascular wounds to the resident’s right first and second toes. Review of the NP progress note dated 06/23/25 revealed the resident was being seen at the request of the nurse due to changes in mental status and dropping oxygen saturation rate of 77%. The resident was placed on three liters of oxygen via nasal cannula and his oxygen saturation rate dropped to 71%. The resident was not answering questions or following commands. The resident was non-verbal and only yells out like he was in pain. The note indicated the resident definitely had a major decline in his baseline. The resident was sent to the ER via emergency medical services (EMS). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the hospital Discharge summary dated [DATE] provided by the facility revealed the resident was readmitted to the local acute care hospital for altered mental status and sepsis likely source left foot postop infection/worsening gangrene. The resident’s family indicated the had had an altered mental status for the past four days. The resident was scheduled for a left above knee amputation (AKA) pending family approval. The resident was started on broad spectrum antibiotics for a white blood cell count (WBC) of 27.9. However the resident deteriorated rapidly and was noted to have bradypnea and bradycardia upon returning from CT scan with rapid apnea. The resident was pronounced at 7:55 P.M. on 06/23/25. The primary cause of death was cardiopulmonary arrest and the secondary cause was severe sepsis from left foot gangrene. Further review of the medical record revealed no physician or NP addressed the resident’s wounds or monitored the resident’s laboratory tests for changes in condition while in the facility. On 08/06/25 at 10:08 A.M., an interview with the Registered Nurse (RN) #147 revealed she functioned as the facility wound nurse. The RN said she monitors pressure ulcers and vascular wounds and the floor nurses monitor the others skin conditions. On 08/06/25 at 11:10 A.M., an interview with Nurse Practitioner (NP) #235 revealed her hours at the facility were Monday through Friday from 7:00 A.M. to 1:00 P.M. since February 2025. She said she had no part of wounds as the facility has a WNP. On 08/12/25 at 9:05 A.M., an interview with the Director of Nursing verified all wound should be assessed and monitored. The DON verified the surgical wound, vascular wound, skin tears and pressure ulcer should be assessed weekly and as needed and a treatment in place until the wounds are healed. The DON verified the resident’s change in condition was not addressed in a timely manner. 2. Review of the medical record for Resident #79 revealed an initial admission date of 12/17/20 with the diagnoses including but not limited to multiple sclerosis, diabetes mellitus, vitamin D deficiency, anxiety disorder, encounter for palliative care, opioid use, pain, cerebellar ataxia, history of falling, severe protein malnutrition, hypertension, chronic pain syndrome and adult failure to thrive. Review of the resident’s comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was dependent on staff for all activities of daily living (ADL). Review of the weekly skin and wound evaluation dated 08/07/25 revealed the resident was found to have a pressure ulcer to the right lateral elbow that had worsened in size. The note indicated the resident had a skin tear medial to the wound bed and it conjoined with the pressure ulcer which was the reasoning for the larger measurements in surface area. Review of the medical record revealed no documentation on when the skin tear was found or how the skin tear occurred. On 08/11/25 at 12:10 P.M., interview with Registered Nurse (RN) #147 verified the facility had no documentation of when and how the skin tear occurred. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/12/15 at 12:45 P.M., an interview with the Director of Nursing (DON) revealed she spoke with Registered Nurse (RN) #128 and the wound was from the resident’s Broda chair because her hospice company documented her up in the chair on 08/02/25 and she called the resident’s company and requested the resident’s hospice notes. The DON also verified the resident's hospice company does not provide documentation of the visit to the facility. 3. Review of the medical record for Resident #106 revealed an initial admission date of 08/04/25 with the diagnoses including but not limited to anemia, acute duodenal ulcer with hemorrhage, constipation, depression, diabetes mellitus, seasonal allergic rhinitis, hyperlipidemia, glaucoma, COPD, CHF, presence of coronary angioplasty implant and graft, ASHD, ischemic cardiomyopathy, CKD, insomnia, nicotine dependence, alcohol dependence, anxiety disorder. Review of the resident’s admission nursing evaluation dated 08/04/25 revealed the resident was admitted to the facility with a skin condition to his left elbow. The assessment did not indicated what the skin condition was or assess the skin condition. The assessment indicated the resident had no cognitive deficit. Review of the baseline plan of care contained with the admission nursing evaluation dated 08/04/25 revealed the resident had actual skin breakdown. Interventions included apply (specify: pressure relieving/reducing mattress, pillows, etc.) to protect the skin while in bed, encourage good nutrition and hydration in order to promote healthier skin, provide dietary supplements as ordered, observe location, size and treatment of skin injury, report abnormalities, failure to heal and signs/symptoms of infection, maceration, etc. to physician. Review of the baseline plan of care contained with the admission nursing evaluation dated 08/04/25 revealed the resident had the potential for skin breakdown. Interventions included Braden scale per protocol, conduct weekly head to toe skin assessments, documents and report abnormal findings to the physician, follow facility policies/protocols for the prevention/treatment of skin integrity, provide diet as ordered, observe and document food acceptance and offer supplements as needed and turn and reposition every (blank) hours and as needed. Review of the resident’s skin and wound total body skin assessment for 08/05/25, 08/06/25 and 08/11/25 revealed no new skin issues were identified. Review of the progress note dated 08/05/25 at 8:17 P.M. revealed the second skin assessment was completed and an area to the left elbow was observed. Orders for treatment and the treatment was in place. The note indicated bruising was also observed to bilateral arms. Further review of the resident’s progress notes revealed no entry indicating what the area to the left elbow was identified as. Review of the resident’s physician orders for August 2025 identified an order dated 08/05/25 to cleanse the skin tear to the left elbow with normal saline, pat dry, apply xeroform and cover with bordered gauze daily and as needed. Further review of the physician orders revealed no order to monitor the bruising to the resident’s bilateral arms. On 08/12/25 at 11:32 A.M., an interview with the Director of Nursing (DON) verified the resident had no assessment of the skin tear and no monitoring of the skin tear and bruising. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Review of Resident #109’s medical record revealed an admission date of 01/15/25 and a discharge date of 04/13/25 with diagnoses including pneumonia, cognitive communication deficit, generalized anxiety disorder, and chronic respiratory failure. Review of Resident #109’s five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #109’s plan of care dated 01/27/25 revealed the resident was at risk for abnormal bleeding/bruising related to medication use. Interventions included administering medications as ordered, observing for signs of complications such as bruising, and obtaining labs as ordered. Review of Resident #109’s plan of care dated 03/02/25 revealed they were at risk for fall related injury and falls related to gait and balance problems, history of falls, incontinence, diagnoses, and psychoactive drug use. Interventions included administering medications as ordered, anticipating and meeting needs, assessing risk level, completing fall risk assessment, dose reduction as appropriate, encouraging appropriate footwear, encouraging to use reacher for items out of reach, following fall protocol, and therapy evaluation and treatment as ordered. Review of Resident #109’s physician order dated 03/21/25 to 04/14/25 revealed an order for Apixban (an anticoagulant) 2.5 milligrams (mg) one tablet by mouth twice a day for atrial fibrillation. Review of Resident #109’s progress note dated 04/10/25 revealed the resident had bruises on the left side of her upper body from using a gait belt during transfer by staff. The resident denied any pain from the bruises. An X-ray was ordered by the Certified Nurse Practitioner (CNP) to rule out any fracture. Review of Resident #109’s progress note dated 04/11/25 revealed an order to discontinue the order for an X-ray to the arm. The resident did not have any falls or incidents that could cause injuries. Review of Resident #109’s interdisciplinary team note dated 04/11/25 revealed the team met to review a bruise noted to the residents left upper body. It was noted that there was a bruise to her left underarm that extended under her left breast. After speaking with the resident and Certified Nursing Assistant (CNA) it was revealed that during a transfer from the bed to the wheelchair the resident's knees gave out. The CNA tightened the gait belt and guided the resident to the wheelchair to prevent a fall. Intervention was to offer and encourage two person assistance with all transfers. Review of Resident #109’s medical record revealed no measurement of the bruise or further monitoring. Review of Resident #109’s hospital notes dated 04/13/25 revealed a CT scan was done. The resident was found to have a chest wall hematoma that was being monitored to ensure it was not spreading. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/07/25 at 10:28 A.M. with Assistant Director of Nursing (ADON) #128 revealed initially they thought the resident had an unwitnessed fall, so an X-ray was ordered. When they figured out what happened the nurse practitioner cancelled the X-ray because the resident had not fallen. They were notified of the bruising by therapy and the actual incident occurred on 04/09/25. ADON #128 stated she brought the CNA to the residents room and had her explain what happened. She had the resident had started to fall and the gait belt started to slide up and it tightened around her breast area. They educated the CNA that she should have let the nurse know of the incident. She verified there was no monitoring of the bruise, but stated it was a big bruise and they would have noticed if it had gotten bigger. She indicated it was from the waist up to the shoulder. She reported the incident happened quickly and she would not have wanted the resident to fall. Review of the facility policy titled, Skin Management, last revised 08/14/24 revealed a skin tear is an opening or break in the skin due to friction, shear or trauma and is technically a separation of the epidermis and dermis. All skin tears will be evaluated, documented and treated based on physician orders. On occurrence all skin tears will be reported to the licensed nurse, an incident and accident report is to be completed, the licensed nurse is responsible for documenting skin tears upon occurrence and monitoring on a weekly basis until healed. This deficiency represents noncompliance related to complaint 2580593, 2574352, and 1399347.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, open and closed medical record review, interviews and facility policy review, the facility failed to ensure timely accurate comprehensive assessment of pressure ulcers/injury. Additionally, the facility failed to ensure skin interventions were implemented as physician ordered. This affected three residents (#32, #79 and #108) of three residents reviewed for pressure ulcers. The facility census was 107. Findings Include:1. Review of the closed medical record for Resident #108 revealed an initial admission date of 04/26/25 with the latest readmission of 06/13/25 with the diagnoses including but not limited to other mechanical complication of surgically created arteriovenous fistula, acquired absence of other left toes, encounter for orthopedic aftercare following surgical amputation, generalized muscle weakness, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease ,end stage renal disease (ESRD), diabetes mellitus, pressure induced deep tissue injury (DTI), to left heel, DTI (Persistent non-blanchable deep red, maroon or purple discoloration) to left ankle, atrial fibrillation, anemia, opioid use, depression, chronic obstructive pulmonary disease, open-angle glaucoma right eye, asthma, arteriovenous fistula, long term use of insulin, pulmonary hypertension, long term use of anticoagulants, dependence on renal dialysis, chronic congestive heart failure, personal history of malignant neoplasm of prostate, peripheral vascular disease, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, cardiomyopathy, hyperlipidemia, and atherosclerotic heart disease. Review of the resident's readmission nursing comprehensive evaluation dated 06/13/25 revealed the resident was admitted to the facility with amputated first, second and third toes to the left foot. The assessment did not address the wounds to the left heel, left lateral ankle and the right heel. Review of the resident's skin and wound evaluation dated 06/13/25 revealed the resident was readmitted to the facility with an unstageable (Obscured full-thickness skin and tissue loss.) pressure ulcer to the resident's right heel. The wound was described as having slough (Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture.) and/or eschar (Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like.). The assessment had no measurements for the wound. Review of the resident's skin and wound evaluation dated 06/16/25 revealed the resident was readmitted to the facility with an unstageable pressure ulcer to the right heel with slough and/or eschar measuring 1.2 centimeters (cm) by 0.8 cm by 0.2 and described as 100% slough. The wound had a light amount of exudate described as serosanguineous. The facility implemented the treatment cleanse with normal saline, apply Medi-honey, place calcium alginate and cover with boarded dressing. Review of the resident's skin and wound evaluation dated 06/16/25 revealed the resident was readmitted to the facility with an unstageable pressure ulcer to the left lateral malleolus with slough and/or eschar measuring 2.2 cm by 2.1 cm by 0.3 cm and described as 100% slough. The wound had a moderate amount of exudate described as serosanguineous. The facility implemented the treatment cleanse with normal saline, apply Medi-honey, place calcium alginate and cover with ABD pad and wrap with Kerlix. Review of the resident's skin and wound evaluation dated 06/16/25 revealed the resident was readmitted to the facility with a Deep Tissue Injury (DTI) pressure ulcer to the left heel measuring 5.7 cm by 6.7 cm and described as 100% epithelial with no exudate. The facility implemented the treatment to cleanse with normal saline, apply betadine soaked gauze, cover with ABD pad and wrap with Kerlix. Review of the resident's five-day MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent for toileting, bathing, transfers, required substantial/maximal assistance with dressing and required partial/moderate assistance for bed mobility. The assessment indicated the resident was at risk for skin breakdown and had two unstageable pressure ulcers on admission and one deep tissue injury present on admission. The MDS did not address the vascular wounds to the resident's right first and second toes. The resident also had a surgical wound. The facility implemented pressure reducing device to bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care and surgical wound care. Review of the medical record revealed no comprehensive assessments of the wound to the left heel, left lateral ankle and right heel. Further review revealed no physician ordered treatment was in place for the treatment of the wounds until 06/16/25 when the first comprehensive assessment was completed. On 08/12/25 at 9:05 A.M., an interview with the Director of Nursing (DON) verified the resident's wounds were not comprehensively assessed in a timely manner and no treatment was provided to the wounds to the resident's surgical incision, the wound to

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on open and closed record review and interviews, the facility failed to ensure bowel and bladder tracking to reflect an accurate reflection of the resident's bowel and bladder function. This affected three residents (#19, #59 and #108) of three residents reviewed for decline in bowel and bladder function. Additionally, the facility failed to timely assess and treat a urinary tract infection (UTI) for Resident #38. This affected one resident (#38) of three residents reviewed for UTI's. The facility census was 107.Findings Include:1.Review of the medical record for Resident #19 revealed an initial admission date of 04/24/25 with the diagnoses including but no limited to congestive heart failure, atrial fibrillation, hypertension, rheumatoid arthritis, insomnia, hyperlipidemia, vascular dementia, osteoporosis, arthritis, constipation, sensorineural hearing loss and adult failure to thrive. Review of the resident’s admission nursing comprehensive evaluation dated 04/18/25 revealed the resident was continent of both bowel and bladder. Review of the resident’s comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent on staff for toileting and transferring to the toilet was not attempted. The assessment indicated the resident was frequently incontinent of both bowel and bladder. Review of the quarterly nursing comprehensive evaluation dated 07/18/25 revealed the resident was continent of both bowel and bladder. Review of the resident’s quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent on staff for toileting and transferring to the toilet. The assessment indicated the resident was always incontinent of both bowel and bladder. Review of the plan of care revealed the resident had no care plan addressing her bowel and bladder incontinence. 2. Review of the medical record for Resident #59 revealed an initial admission date of 12/06/24 with the diagnoses including but not limited to diabetes mellitus, encounter for other orthopedic aftercare, end stage renal disease, hypertension, cardiomegaly, chronic obstructive pulmonary disease, hypothyroidism, insomnia, peripheral vascular disease, dysphagia, atrial fibrillation and dependence on renal dialysis. Review of the resident’s admission nursing comprehensive evaluation dated 12/06/24 revealed the resident was continent of both bowel and bladder. Review of the resident’s comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident required supervision or touch assistance with toileting and partial/moderate assistance to transfer on and off the commode. The assessment indicated the resident was occasionally incontinent of both bowel and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly nursing comprehensive evaluation dated 03/06/25 revealed the resident was continent of both bowel and bladder. Review of the resident’s quarterly MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident required supervision or touch assistance with toileting and transfers on and off the commode. The assessment indicated the resident was frequently incontinent of both bowel and bladder. Review of the medical record revealed no interventions implemented by the facility to restore the resident’s bowel and bladder function to his baseline of occasionally incontinent of both bowel and bladder. Review of the plan of care dated 04/06/25 revealed the resident had episodes of bowel and bladder incontinence, bladder frequent, bowel frequent and incontinence was likely to fluctuate. Interventions included resident uses disposable briefs, change frequently and as needed, check resident frequently and as needed for incontinence, wash, rinse and dry perineum, change clothing as needed after incontinence episodes, observe for signs/symptoms of urinary tract infection (UTI), observe skin with each incontinent episode and report any redness, skin integrity changes, rash, pain, etc. to the nurse, provide incontinence care with each incontinent episode and apply moisture barrier as needed. Review of the quarterly nursing comprehensive evaluation dated 06/06/25 revealed the resident was continent of both bowel and bladder. Review of the resident’s quarterly MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident required supervision or touch assistance with toileting and transfers on and off the commode. The assessment indicated the resident was frequently incontinent of bowel and occasionally incontinent of bladder. Review of the medical record revealed no interventions implemented by the facility to restore the resident’s bowel and bladder function to his baseline of occasionally incontinent of both bowel and bladder. Review of the medical record revealed no evidence a bowel and bladder assessment was completed. 3. Review of the closed medical record for Resident #108 revealed an initial admission date of 04/26/25 with the latest readmission of 06/13/25 with the diagnoses including but not limited to other mechanical complication of surgically created arteriovenous (AV) fistula, acquired absence of other left toes, encounter for orthopedic aftercare following surgical amputation, generalized muscle weakness, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease or end stage renal disease, end stage renal disease (ESRD), diabetes mellitus, pressure induced deep tissue injury (DTI) to left heel, (DTI to left ankle unstageable, atrial fibrillation, anemia, opioid use, depression, urinary tract infection, chronic obstructive pulmonary disease, open-angle glaucoma right eye, asthma, pulmonary hypertension, dependence on renal dialysis, chronic congestive heart failure, peripheral vascular disease, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, cardiomyopathy, hyperlipidemia, constipation and atherosclerotic heart disease. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident’s admission nursing comprehensive evaluation dated 04/26/25 revealed the resident was admitted to the facility continent of both bowel and bladder. Review of the resident’s comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident required substantial/maximal assistance with toileting, bathing, dressing, bed mobility and transfers were not attempted. The assessment indicated the resident was frequently incontinent of bladder and frequently incontinent of bladder. Review of the resident’s admission nursing comprehensive evaluation dated 05/29/25 revealed the resident was readmitted to the facility incontinent of both bowel and bladder. Review of the plan of care dated 05/30/25 revealed the resident was at risk for discomfort or adverse side effects, receives antibiotics related to UTI. Interventions included administer medications as ordered, any antibiotic may cause diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions, monitor every shift for adverse reaction, observe for emergence of undesired microorganisms, causing secondary infections such as oral thrush, colitis, and vaginitis and report to physician as indicated. Review of the resident’s five day MDS assessment dated [DATE] revealed the resident had no cognitive impairment. The assessment indicated the resident required partial/moderate assistance with toileting, bathing, substantial/maximal assistance with dressing, bed mobility and transfers. The assessment indicated the resident was frequently incontinent of bladder and always incontinent of bowel. Review of the resident’s readmission nursing comprehensive evaluation dated 06/13/25 revealed the resident was readmitted to the facility continent of both bowel and bladder. Review of the resident’s five-day MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent for toileting, bathing, transfers, required substantial/maximal assistance with dressing and required partial/moderate assistance for bed mobility. The assessment indicated the resident was always incontinent of both bowel and bladder. On 08/12/25 at 11:13 A.M., interview with Minimum Data Set (MDS) Coordinator #215 revealed the facility documents on the resident's bowel and bladder continence once a shift. She revealed she bases the residents bladder incontinence on the two entries entered daily and they tend to fluctuate. The MDS Coordinator revealed the facility does not track the resident's bowel and bladder function with each episode during the MDS seven day window. The MDS Coordinator verified the facility does not complete bowel and bladder assessments or participate in a restorative or maintenance program to maintain resident's baseline continence. 4. Review of Resident #38’s medical record revealed an admission date of 04/16/21 with diagnoses including schizoaffective disorder, paranoid personality disorder, dementia, delirium, anxiety disorders, and encephalopathy. Review of Resident #38’s Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #38’s plan of care dated 12/21/23 revealed the resident was incontinent of bladder and bowel related to aging process. Interventions included using disposable briefs, checking every two hours and as needed for incontinence, and providing incontinence care with moisture barrier as needed. Review of Resident #38’s change of condition progress note dated 07/22/25 revealed the resident was complaining of left side and lower back pain. There was a new order for polyethylene glycol for constipation and a Kidney, ureter, and bladder (KUB) x-ray. Review of Resident #38’s KUB results dated 07/23/25 revealed the resident had a nonobstructive bowel gas pattern. Review of Resident #38’s medical record from 07/24/25 to 07/27/25 revealed no further mention of the resident’s left sided pain. Review of Resident #38’s physician order dated 07/28/25 revealed an order for a urinary analysis with culture and sensitivity for urinary tract infection (UTI). Review of Resident #38’s progress notes from 07/28/25 to 08/09/25 revealed no further mention of a UTI. Review of Resident #38’s urine culture collected 07/29/25 and reported 08/01/25 revealed it did not indicate any bacteria present in the urine but, it indicated what the bacteria was sensitive to. Review of Resident #38’s urine screen and culture collected 08/05/25 and reported 08/07/25 revealed her results were abnormal, and she had bacteria present that was sensitive to specific bacteria, however, no bacteria was listed. Review of Resident #38’s lab result reported 08/06/25 revealed the resident had Escherichia coli in her urine. Review of Resident #38’s nurse practitioner note dated 08/08/25 revealed the resident was on ciprofloxacin for a urinary tract infection. The nurse practitioner suspected the flank pain was more musculoskeletal in nature. Interview on 08/11/25 at 12:00 P.M. with the Director of Nursing (DON) revealed on 07/22/25 or 07/23/25 the resident reported flank plan. This was thought to be constipation, so when it came back negative they reassessed her and decided to check for a UTI. It came back negative so she was checked for a urinary tract infection. The first results on 08/01/25 came back without the organism, so they sent it back. She was unsure of what happened with the lab and verified there was no documentation of the nurse practitioner or physician being notified of any results. Additionally, there was no documentation of the physician or nurse practitioner’s plans after the negative KUB results. From the negative KUB to an order for a urinary analysis there was five days. This deficiency represents noncompliance investigated under complaint 2580593 and 2574352.

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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** Based on interview, medical record review, the facility failed to have orders in place for continuous oxygen use for Resident #26. This affected one resident (#26) of three residents reviewed for oxygen use. The facility census was 107.Findings include:Review of Resident #26's medical record revealed an admission date of 06/18/25 with diagnoses including chronic heart failure, acute respiratory failure, end stage renal disease, diabetes mellitus, and depression. Review of Resident #26's minimum data set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition. Review of Resident #26's plan of care revealed it did not address his oxygen usage. Review of Resident #26's physician orders from 06/18/25 to 08/06/25 revealed no orders for oxygen.Review of Resident #26's progress note dated 06/18/25 revealed the resident arrived to the facility with oxygen on at two liters.Review of the skilled nursing notes dated 6/20/25, 07/04/25, 07/06/25, 07/07/25, 07/08/25, 07/09/25, 07/11/25, 07/12/25, 07/13/25, 07/15/25, 07/16/25, 07/18/25, 07/19/25, 07/22/25, 07/23/25, 07/24/25, 07/26/25, 07/29/25, 07/31/25, 08/01/25, 08/04/25, 08/05/25, 08/06/25, revealed the resident received oxygen. Review of Resident #26's physician order dated 08/07/25 revealed an order for oxygen at two liters via continuous oxygen.Interview on 08/11/25 at 11:34 A.M. with the Director of Nursing (DON) verified Resident #26 had been receiving oxygen his entire stay and an order and care plan had not been in place.This deficiency represents noncompliance investigated under Complaint Number 2574352.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review, the facility failed to assess Resident #26's pain, document location of pain with administration of 'as needed' pain medications, and administering pain medications according to orders. This affected one resident (#26) of three residents reviewed for pain. The facility census was 107.Findings include: Review of Resident #26's medical record revealed an admission date of 06/18/25 with diagnoses including chronic heart failure, acute respiratory failure, end stage renal disease, diabetes mellitus, and depression. Review of Resident #26's minimum data set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition. Review of Resident #26's progress note dated 07/20/25 revealed the resident called emergency medical services for pain in his legs.Review of Resident #26's progress note dated 07/20/25 revealed the resident returned from the hospital with a new order for pain medication. Review of Resident #26's physician order dated 07/21/25 revealed an order for one tablet every eight hours as needed for severe pain for three days.Review of Resident #26's physician order dated 07/21/25 to 07/23/25 revealed an order for hydrocodone-acetaminophen 325 mg one tablet by mouth every eight hours as needed for severe pain for three days. Nonpharmacological interventions were to be attempted.Review of resident #26's physician order beginning 07/23/25 revealed an order for hydrocodone-acetaminophen 325 mg one tablet by mouth every eight hours as needed for severe pain. Nonpharmacological interventions were to be attempted.Review of Resident #26's Medication Administration Record for July 2025 and 08/01/25 to 08/09/25 revealed hydrocodone-acetaminophen was administered on 07/21/25 for an unknown pain and a pain of seven, on 07/22/25 for a pain of six and eight, on 07/25/25 for a pain of eight, on 07/26/25 for a pain of seven, on 07/29/25 for a pain of four, on 07/31/25 for a pain of three, on 08/02/25 for a pain of three, on 08/05/25 for a pain of seven and four, on 08/06/25 for a pain of four, on 08/08/25 for a pain of eight and six, and on 08/09/25 for a pain of eight.Review of Resident #26's progress notes revealed there was no description of the pain for medication administration on 07/21/25, 07/22/25, 07/25/25, 07/26/25, 07/29/25, 07/31/25, 08/02/25, 08/05/25, 08/06/25, 08/08/25, and 08/09/25.Review of Resident #26's plan of care revealed it did not address his pain.Interview on 08/11/25 at 2:24 P.M. with the Director of Nursing (DON) revealed a severe pain would be a pain of seven or above. She verified pains of three and four were not considered severe. The DON verified there was no description of pain or assessment of Resident #26's change in pain.Interview on 08/11/25 at 2:47 P.M. with Resident #26 revealed his pain was continuous and it was in his feet, he believed it was up to diabetic neuropathy.Review of the policy 'pain management' dated 04/28/25 revealed residents were to be monitored for the presence of pain and evaluated when there was a change in condition and whenever new pain was suspected. Staff was asked to determine the location of pain. Each resident identified with pain was to have a pain management care plan.This deficiency represents noncompliance investigated under Complaint Number 2574352 and 2580593.

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F 0698 Level of Harm - Minimal harm or potential for 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** Based on interview and medical record review, the facility failed to educate Resident #108 upon refusal of dialysis and notify Resident #102's family of his refusal to attend dialysis. This affected two residents (#102 and #108) of three residents reviewed for dialysis. The facility census was 107.Findings include: 1.Review of Resident #108's medical record revealed an admission date of 04/26/25 and a discharge date of 06/24/25 with diagnoses including muscle weakness, end stage renal disease with dependence on dialysis, type two diabetes mellitus, fracture of sacrum, pressure induced deep tissue damage of left heel, pressure ulcer of left ankle, chronic obstructive pulmonary disease, alcohol abuse, and peripheral vascular disease. Review of Resident #108's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. Review of Resident #108's plan of care dated 04/26/25 revealed resident was at risk for complications related to dialysis. Interventions included encouraging him to go for the scheduled appointments, observing for signs of fluid retention, observing for signs of infection to access site, observing for bruising or bleeding, and palpitating for the presence of thrill and listen for bruit as needed. The plan of care was not specific to the resident, did not include where he went to dialysis, how to contact them, or when he was to go to dialysis. Review of Resident #108's physician order dated 04/29/25 to 05/14/25 revealed he was to attend hemodialysis every Tuesday, Thursday, and Saturday. Review of Resident #108's progress note dated 05/10/25 revealed the resident refused dialysis due to agitation and discomfort. There was no indication the resident was educated on the risks and benefits of refusals.Interview on 08/07/25 at 1:13 P.M. with the Director of Nursing (DON) revealed if a resident refuses dialysis nursing should educate them on the risks and benefits of refusal. Interview on 08/11/25 at 1:07 P.M. with MDS Nurse #215 verified Resident #108's care plan was not specific to the resident. 2. Review of Resident #102's medical record revealed an admission date of 06/05/25 with diagnoses including end stage renal disease (ESRD) with dependence on renal dialysis, cognitive communication deficit, moderate protein-calorie malnutrition, and type two diabetes mellitus. Review of Resident #102's comprehensive Minimum Data Set (MDS) dated [DATE] revealed he had impaired cognition.Review of Resident #102's plan of care dated 06/05/25 revealed the resident was at risk for complications related to dialysis due to ESRD and history of noncompliance with hemodialysis. Interventions included administering medications as ordered, checking and reinforcing dressing to access cite as needed, encourage to avoid contact with individuals with infection, hemodialysis three times a week as ordered, if the resident chose not follow the recommended treatment they were to remind him of the consequences and document on it. Review of Resident #102's progress note dated 06/27/25 revealed the resident refused dialysis. There was no indication his family was notified. Interview on 08/07/25 at 1:13 P.M. with the Director of Nursing (DON) revealed if a resident refuses dialysis nursing should educate the resident and notify the family.This deficiency represents non compliance investigated under Complaint Number 2574352 and 2580593.

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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** Based on closed record review, interview and facility policy review, the facility failed to ensure medication was available for administration as physician ordered. This affected one resident (#108) of three residents reviewed for medication availability. The facility census was 107.Findings Include:Review of the closed medical record for Resident #108 revealed an initial admission date of 04/26/25 with the latest readmission of 06/13/25 with the diagnoses including but not limited to other mechanical complication of surgically created arteriovenous (AV) fistula, acquired absence of other left toes, encounter for orthopedic aftercare following surgical amputation, generalized muscle weakness, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease or end stage renal disease, end stage renal disease (ESRD), diabetes mellitus, pressure induced deep tissue injury (DTI) to left heel, DTI to left ankle, atrial fibrillation, anemia, opioid use, depression, urinary tract infection, chronic obstructive pulmonary disease, asthma, pulmonary hypertension, long term use of anticoagulants, dependence on renal dialysis, chronic congestive heart failure, peripheral vascular disease, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, cardiomyopathy, hyperlipidemia, constipation and atherosclerotic heart disease. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the May 2025 Medication Administration Record (MAR) revealed the resident had not received the medication Calcitriol 0.25 micrograms (mcg) by mouth daily for hypocalcemia on 04/27/25, 04/28/25 and 04/29/25. Further review of the MAR revealed the resident had not received the medication Sevelamer 800 milligrams (mg) with the special instructions to administer three tablets by mouth three times a day, the resident also was not provided with Diphenhydramine-Zinc Acetate 2-0.1% cream with the special instructions to apply to skin topically twice daily for skin itching/irritation on 04/26/25, 04/27/25, 04/28/25 and 04/29/25 when the medication was discontinued. The resident was also not provided with Brimonidine Tartrate Ophthalmic solution 0/2% with the special instruction to instill one drop in right eye three times daily on 04/26/25. Review of the June 2025 MAR revealed the resident had not been administered the medications Sevelamer 800 mg with the special instructions to administer three tablets by mouth three times a day on 06/14/25, 06/16/25 and 06/17/25. On 08/11/25 at 12:10 P.M., an interview with the Director of Nursing (DON) verified the medication was not available for administration as physician ordered. Review of the facility policy titled, Medication Administration, last revised 10/17/23 revealed resident medications are administered in an accurate, safe, timely and sanitary manner. This deficiency represents non-compliance investigated under Complaint Number 1399441.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of dishwasher sanitation logs, the facility failed to ensure the dietary manager was competent to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect 104 of 107 residents who consumed food from the kitchen the facility identified three residents (#2, #84, and #92) who ate nothing by mouth. The facility census was 107.Findings include: 1. Observation on 08/06/25 from 9:40 A.M. to 10:08 A.M. with Dietary Manager #130 revealed multiple concerns in the kitchen including:a. Multiple broken baseboards including one next to the three-compartment sink, one across from the entry way, and one to the right of the oven. Dietary Manager #130 verified findings at time of the observation.b. The three-compartment sink was leaking from the bottom into a bucket on the floor. The area surrounding this bucket was a rusty brown color and had a build up of dirt. The wall behind the three-compartment sink was chipped. Dietary Manager #130 verified the sink was leaking and the area was unclean, she believed they were planning on replacing the whole area and stated she had told maintenance of the issue.c. The food prep sink had a leak from the faucet into the sink. Dietary Manager #130 verified the leak and reported maintenance was aware.d. Throughout the kitchen there were multiple areas of the ceiling covered in splatters. Dietary Manager #130 reported she thought maintenance was responsible for this.e. Under tables, equipment, and the mixer that were up against the wall revealed the floor had a buildup of dirt, food debris, and disposable items like twist ties and plastic bags. Dietary Manager #130 verified this observation.f. The steamtable from below the food prep surface was unclean, there was food splatter and crumbs. Dietary Manager #130 verified this and reported they were prioritizing the food surfaces when cleaningg. The Robot Coup food processor base had food splatter on it. Dietary Manager #130 verified this at time of observation.h. The side of the convection oven was covered in grease splatter. Dietary Manager #130 verified this at time of observation.i. The hood vents had a build-up of grease and dust. Dietary Manager #130 verified this and said she believed maintenance was responsible for this. Interview on 08/06/25 from 9:40 A.M. to 10:08 A.M. with Dietary Manager #130 verified the kitchen was not clean. She reported they were short staffed and had been prioritizing everyday cleaning over deep cleaning. Interview on 08/06/25 at 2:23 P.M., 2:47 P.M., and 3:56 P.M. with Plant and Maintenance Director #129 revealed he was unaware of leaks in the kitchen. 2. Observation on 08/06/25 from 9:40 A.M. to 10:08 A.M. of the kitchen revealed Dietary Aide #226 putting away trays that had been removed from the dishwasher. There was one rack of trays remaining on the clean side of the dishwasher and next to it were piles of soiled cups. Dietary Manager #130 put a rack of trays into the dishwasher and ran it, it was very soapy and soap leaked out of the front into a bucket. During the first run of the dishwasher the temperature was at 110 degrees Fahrenheit (F) and she was unable to verify the sanitation level as the strip did not change color. Dietary Manager #130 did not check the temperature at that time. The second time she ran the dishwasher the temperature reached 120 degrees F, but once again the strip did not register sanitation level. The dishwasher had pumps connected to the tubing for the sanitizer, this pump was not observed moving during the first three runs of the dishwasher. During the second observation Dietary Manager #130 began pressing a button above the pumps and by the fourth run, the pump was moving and sanitizer was observed going into the dishwasher sump. However, the test strip did not change color. Dietary Manager #130 verified this was a chemical dishwasher and she was unable to verify sanitation level. Interview with Dietary Aide #226 verified she had washed dishes in the dishwasher but had not checked the sanitation level or temperature that morning.3.Observation and interview on 08/06/25 from 1:07 P.M. to 1:50 P.M. revealed Dietary Manager #130 did not think the sanitation strips were working right, she reported they did not change color when she dipped it directly into the sanitizer. The dietary aides were observed putting dishes through the dishwasher, the three-compartment sink was empty. Dietary Manager #130 verified she was still unable to verify the dishwasher was running appropriately and the aides were using it anyways. The dietary manager reported she expected the dietary aides to check the sanitation level and temperature of the dishwasher with the first rack of dishes in the morning, she verified this had not been done. Dietary Manager #130 reported the sanitizer had been delivered yesterday and the staff connected it. She reported the machine determined the mount of chemicals and other than connecting the sanitizer nobody in the facility had to do anything. Interview on 08/06/25 at 2:23 P.M., 2:47 P.M., and 3:27 P.M. with Plant and Maintenance Director #129 revealed he was unaware of any concerns with the dishwasher. He reported when a new chemical was

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, review of kitchen staffing schedule, review of dishwasher sanitation log,and review of staff personnel file revealed the facility failed to employ sufficient staff to maintain a clean kitchen. Additionally, they failed to ensure staff were competent to ensure the dishwasher was running appropriately and qualified to be a cook. This had the potential to affect 104 residents who consumed food from the kitchen. The facility identified three residents (#2, #84, and #92) who ate nothing by mouth. The facility census was 107.Findings include:Findings include:1.Observation on 08/06/25 from 9:40 A.M. to 10:08 A.M. with Dietary Manager #130 revealed multiple concerns in the kitchen including:a. Multiple broken baseboards including one next to the three-compartment sink, one across from the entry way, and one to the right of the oven. Dietary Manager #130 verified this.b. The three-compartment sink was leaking from the bottom into a bucket on the floor. The area surrounding this bucket was a rusty brown color and had a buildup of dirt. The wall behind the three-compartment sink was chipped. Dietary Manager #130 verified the sink was leaking and the area was unclean,' she believed they were planning on replacing the whole area.c. Throughout the kitchen there were multiple areas of the ceiling covered in splatters. Dietary Manager #130 reported she thought maintenance was responsible for this.d. Under tables, equipment, and the mixer that were up against the wall revealed the floor had a buildup of dirt, food debris, and disposable items like twist ties and plastic bags. Dietary Manager #130 verified this observation.e. The steamtable from below the food prep surface was unclean, there was food splatter and crumbs. Dietary Manager #130 verified this and reported thy were prioritizing the food surfaces when cleaningf. The Robot Coup food processor base had food splatter on it. Dietary Manager #130 verified this.g. The side of the convection oven was covered in grease splatter. Dietary Manager #130 verified this.h. The hood vents had a build-up of grease and dust. Dietary Manager #130 verified this and said she believed maintenance was responsible for this.Interview on 08/06/25 from 9:40 A.M. to 10:08 A.M. with Dietary Manager #130 verified the kitchen was not clean. She reported they were short staffed and had been prioritizing everyday cleaning over deep cleaning. She stated they needed one cook and two aides in the morning and in the afternoon and they did not often have that. They were really short on cooks and she had been filling in.Review of the kitchen schedule from 07/08/25 to 08/05/25 revealed on 07/08/25 there was no morning cook and only one aide in the afternoon, on 07/09/25 there was no afternoon aides, on 07/10/25 there was no morning cook and only one afternoon aide, on 07/11/25 there was no morning cook and only one morning aide, on 07/12/25 there was no afternoon aides, on 07/13/25 there were no afternoon aides, on 07/14/25 there was only one afternoon aide, on 07/15/25 there was no morning cook and only one afternoon aide, on 07/16/25 there was no morning cook, on 07/17/25 there was no morning cook and only one afternoon aide, on 07/18/25 there was no morning cook and only one morning aide, on 07/19/25 there was no morning cook and only one afternoon aide, on 07/20/25 there was only one aide in the morning and afternoon, on 07/21/25 there were no afternoon aides, on 07/22/5 there was no morning cook and only one aide in the afternoon, on 07/23/25, there was no morning cook and only one aide in the afternoon, on 07/24/25 there was no morning cook and no afternoon aides, on 07/25/25 there was no morning cook and only one aide in the morning and afternoon, on 07/26/25 there was no morning cook and only one aide in the morning and afternoon, on 07/27/25 there was no morning cook, only one morning aide, and no afternoon aides, on 07/28/25 there was no morning cook and no afternoon aides, on 07/29/25 there was no morning cook, only one morning aide, and no afternoon aides, on 07/30/25 there was no morning cook and only one morning aide, on 07/31/25 there was no morning cook and only one afternoon aide, on 08/01/25 there was no morning cook and only one morning aide, on 08/02/25 there was no morning cook and only one afternoon aide, on 08/03/25 there was no morning cook and only one morning aide, on 08/02/25 there was no morning cook and only one afternoon aide, on 08/03/25 there was no morning cook and only one afternoon aide, on 08/04/25 there were no scheduled cooks and only one afternoon aide, and on 08/05/25 there was no morning cook and one afternoon aide.2. Observation 0n 08/06/25 from 9:40 A.M. to 10:08 A.M. of the kitchen revealed Dietary Aide #226 putting away trays that had been removed from the dishwasher. There was one rack of trays remaining on the clean side of the dishwasher and next to it were piles of soiled cups. Upon four attempts at running the dishwasher Dietary Manager #130 was unable to confirm the sanitizer was running at an appropriate level. Interview with Dietary Aide #226 verified she had washed dishes in the dishwasher but had not checked the sanitation level or temperature that morning.Interview on 08/06/25 from 1:07 P.M. to 1:50 P.M. revealed Dietary Manager

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	366457	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamilton 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview the facility failed to ensure food was served at a palatable temperature. This had the potential to affect 104 residents who consumed food from the kitchen the facility identified three residents (#2, #84, and #92) who ate nothing by mouth.Findings include: Interview on 08/06/25 from 12:25 P. M. to 12:55 P.M. with Resident #96 and #97 revealed the food was not always hot when it got to them. Interview with Resident #102 revealed the food was often cold and lunch on that day had been cold as well. Observation on 08/06/25 at 12:30 P.M. revealed the last trays being passed on the E Hall, the cart was open and remained open as Certified Nursing Assistant (CNA) #106 passed the trays. She finished the trays at 12:39 P.M.Observation on 08/06/25 at 12:41 P.M. of a test tray with Dietary Manager #130 revealed the stuffed pepper was 119 degrees Fahrenheit (F), the peas were 102 degrees F, and the [NAME] was 103 degrees F. All foods were cold when sampled.Interview on 08/06/25 at 12:41 P.M. with Dietary Manager #130 verified the foods were not at an appropriate temperature. She reported in the kitchen the foods were at least 175 degrees F and should be 140 degrees F when it got to the residents. She reported all carts had left the kitchen by 12:00 P.M.Interview on 08/07/25 at 1:01 P.M. with Resident #48 revealed the food was not always hot when it got to her.Review of the menu for 08/06/25 revealed it included one stuffed pepper, four ounces of rice, four ounces of diced vegetables, and four ounces of bread pudding.This deficiency represents noncompliance investigated under Complaint Number 1399441.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of dishwasher manual, review of sanitation instructions, and facility policy review, the facility failed to maintain a clean and sanitary kitchen and sanitize dishes in an appropriate manner. This had the potential to affect 104 residents who consumed food from the kitchen. The facility identified three residents (#2, #84, and #92) who ate nothing by mouth. The facility census was 107.Findings include: 1.Observation on 08/06/25 from 9:40 A.M. to 10:08 A.M. with Dietary Manager #130 revealed multiple concerns in the kitchen including:a. Multiple broken baseboards including one next to the three compartment sink, one across from the entry way, and one to the right of the oven. Dietary Manager #130 verified this at time of observation.b. The three-compartment sink was leaking from the bottom into a bucket on the floor. The area surrounding this bucket was a rusty brown color and had a build up of dirt. The wall behind the three-compartment sink was chipped. Dietary Manager #130 verified the sink was leaking and the area was unclean,' she believed they were planning on replacing the whole area.c. Throughout the kitchen there were multiple areas of the ceiling covered in splatters. Dietary Manager #130 reported she thought maintenance was responsible for this.d. Under tables, equipment, and the mixer that were up against the wall revealed the floor had a buildup of dirt, food debris, and disposable items like twist ties and plastic bags. Dietary Manager #130 verified this observation.e. The steamtable from below the food prep surface was unclean, there was food splatter and crumbs. Dietary Manager #130 verified this and reported thy were prioritizing the food surfaces when cleaningf. The Robot Coup food processor base had food splatter on it. Dietary Manager #130 verified this.g. The side of the convection oven was covered in grease splatter. Dietary Manager #130 verified this.h. The hood vents had a build-up of grease and dust. Dietary Manager #130 verified this and said she believed maintenance was responsible for this.Interview on 08/06/25 from 9:40 A.M. to 10:08 A.M. with Dietary Manager #130 verified the kitchen was not clean. She reported they were short staffed and had been prioritizing everyday cleaning over deep cleaning.Review of the policy 'Dietary Cleaning and Sanitation' dated 11/19/21 revealed food-contact surface areas should be washed, rinsed, and sanitized after each use, before switching to another food type, or when the tool or items being used may have become sanitized. The dietary manager was responsible for inspecting the kitchen for sanitation.2. Observation 0n 08/06/25 from 9:40 A.M. to 10:08 A.M. of the kitchen revealed Dietary Aide #226 putting away trays that had been removed from the dishwasher. There was one rack of trays remaining on the clean side of the dishwasher and next to it were piles of soiled cups. Dietary Manager #130 put a rack of trays into the dishwasher and ran it, it was very soapy and soap leaked out of the front into a bucket. During the first run of the dishwasher the temperature was at 110 degrees Fahrenheit (F) and she was unable to verify the sanitation level as the strip did not change color. Dietary Manager #130 did not check the temperature at that time. The second time she ran the dishwasher the temperature reached 120 degrees F, but once again the strip did not register sanitation level. The dishwasher had pumps connected to the tubing for the sanitizer, this pump was not observed moving during the first three runs of the dishwasher. During the second observation Dietary Manager #130 began pressing a button above the pumps and by the fourth run, the pump was moving and sanitizer was observed going into the dishwasher sump. However, the test strip did not change color. Dietary Manager #130 verified this was a chemical dishwasher and she was unable to verify sanitation level. Interview with Dietary Aide #226 verified she had washed dishes in the dishwasher but had not checked the sanitation level or temperature that morning.Observation and interview on 08/06/25 from 1:07 P.M. to 1:50 P.M. revealed Dietary Manager #130 did not think the sanitation strips were working right, she reported they did not change color when she dipped it directly into the sanitizer. The dietary aides were observed putting dishes through the dishwasher, the three-compartment sink was empty. Dietary Manager #130 verified she was still unable to verify the dishwasher was running appropriately and the aides were using it anyways. The dietary manager reported she expected the dietary aides to check the sanitation level and temperature of the dishwasher with the first rack of dishes in the morning, she verified this had not been done. Dietary Manager #130 reported the sanitizer had been delivered yesterday and the staff connected it. She reported the machine determined the mount of chemicals and other than connecting the sanitizer nobody in the facility had to do anything.Interview on 08/06/25 at 2:23 P.M., 2:47 P.M., and 3:27 P. M. with Plant and Maintenance Director #129 revealed he was unaware of any concerns with the dishwasher. He reported when a new chemical was connected to the dishwasher kitchen staff should be

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, record review, and review of facility policy, the facility failed to ensure kitchen equipment was in working order and a system was in place to track maintenance requests. This had the potential to affect 104 residents who consumed food from the kitchen the facility identified three residents (#2, #84, and #92) who ate nothing by mouth. The facility also failed to ensure a safe and clean environment when 35 resident rooms had missing transition strips from residents to hallways. This affected 48 residents (#1, #3, #4, #6, #7, #10, #11, #12, #13, #19, #20, #26, #27, #31, #33, #36, #39, #42, #43, #44, #45, #46, #47, #53, #54, #55, #56, #57, #58, #77, #78, #85, #88, #89, #90, #91, #93, #95, #96, #97, #98, #99, #100, #103, #104, #105, #106, and #107) of 107 residents residing in the facility.Findings include: 1.Observation on 08/06/25 from 9:40 A.M. to 10:08 A.M. with Dietary Manager #130 revealed the disposal connected to the dishwasher was being replaced. Dietary Manager #130 reported the disposal had been down for over a month. The three-compartment sink was leaking from the bottom into a bucket on the floor. Additionally, the food prep sink was leaking into the sink. Dietary Manager #130 reported the sinks had been leaking for over a month and she had told maintenance.Interview on 08/06/25 at 2:23 P.M., 2:47 P.M., and 3:56 P.M. with Plant and Maintenance Director #129 revealed he was unaware of leaks in the kitchen. He reported they fixed a leak in the three compartment sink the previous week and was unaware it was leaking again. He reported for the disposal he called the company when he was aware it was down, which was on 07/07/25. The company came out that day and sent a quote on 07/09/25. He reported the quote was approved on 07/24/25. He was unsure why there was a delay in approving it.Interview on 08/07/25 at 10:00 A.M. with the Administrator revealed there were no maintenance work orders to track when requests were submitted and completed. He reported staff called, texted, or found maintenance to notify him of any concerns.Review of the service order for Advanced Mechanical Plus dated 07/07/25, revealed they arrived to work on the garbage disposal and found the unit down. The unit motor was locked and leaking water. An order for a new disposal was to be submitted.Review of the quote from Advanced Mechanical Plus dated 07/09/25 revealed replacement of and maintenance to the disposal would cost $4,468.66.Review of an email to Plant and Maintenance Director #129 on 08/06/25 revealed a timeline for the disposal. On 07/07/25 it was reported that there was a problem with the garbage disposal. On 07/08/25 there was a request for a quote. On 07/09/25 the quote was finished and emailed to a corporate staff member. On 07/23/25 the corporate staff member was emailed to follow up on the quote. On 07/24/25 the corporate staff member approved the quote.Review of the policy 'Maintenance and Repairs of Equipment in Nutritional Services Department' dated 12/19/24 revealed the nutritional professional will notify the maintenance department in writing of any equipment issues. 2. Observation on 08/11/25 at 8:51 A.M., 9:59 A.M., 10:42 A.M., 2:50 P.M., and 4:20 P.M. revealed 35 resident rooms containing residents #1, #3, #4, #6, #7, #10, #11, #12, #13, #19, #20, #26, #27, #31, #33, #36, #39, #42, #43, #44, #45, #46, #47, #53, #54, #55, #56, #57, #58, #77, #78, #85, #88, #89, #90, #91, #93, #95, #96, #97, #98, #99, #100, #103, #104, #105, #106, and #107 were missing the transition strips from the room to the hallway. Some of these rooms had a wide gap between the flooring of the hallway and the flooring of the bedroom and some of them had a build-up of a black sticky residue. Interview on 08/11/25 at 4:20 P.M. with the Administrator verified the missing transition strips. He reported some of the flooring had been replaced up to a year and a half ago and they had been working on ordering new strips.This deficiency represents noncompliance investigated under Complaint Number 1399439.